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APPENDIX C

AREA SURVEYS

SUBCOMMITTEE ON HOSPITALIZATION
COMMITTEE ON FEDERAL MEDICAL SERVICES

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U.S, COMMISSION ON ORGANIZATION OF THE EXECUTIVE BRANCH OF THE GOVERNMENT.

Committee on Federal Medical Services.

## APPENDIX C

AREA SURVEYS

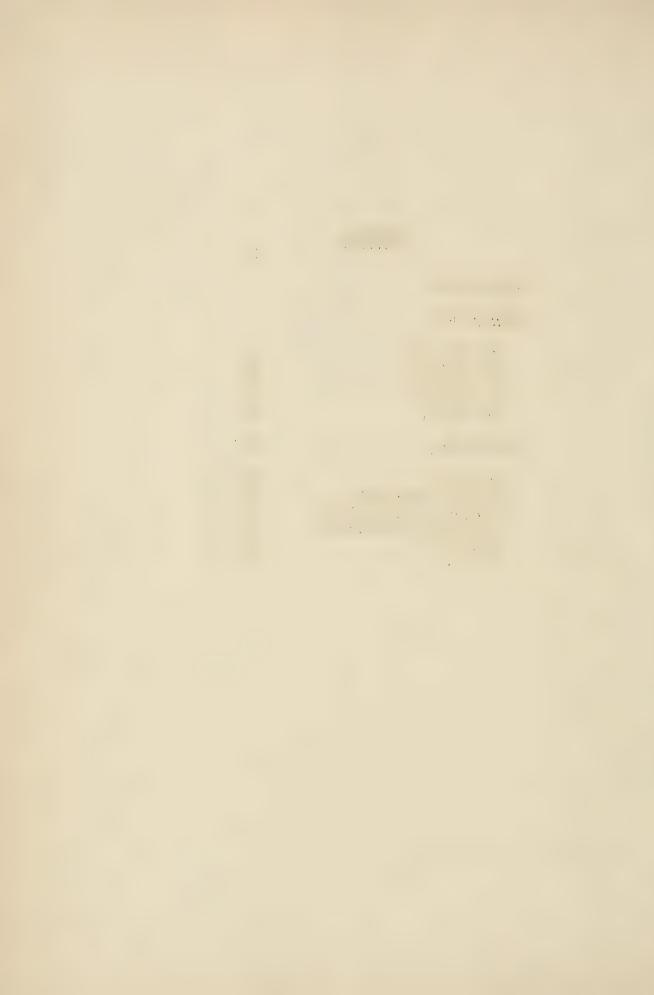
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#### INTRODUCTION

Surveys were made of the federal hospitals in New York, New Orleans, San Francisco, Los Angeles, and San Diego. The purpose was to explore the present operation of the federal medical services in important areas with a view to discovering any major deficiencies which might be corrected by organizational means. In general the occupancy shown for the hospitals at time of survey is representative of that during the entire fiscal year 1948.

## NEW YORK CITY AREA

Each of the major federal medical services has at least one hospital in the New York City area, and in all there are 11 within a radius of about 20 miles, with good interconnecting transportation. (Four minor units have been excluded from this report. Two Naval dispensaries and two Merchant Marine dispensaries had a total of four patients at the end of June.) The total capacity of the 11 hospitals is 8,300 beds, of which 6,900 were in operation at the time of survey. Their combined census was 5,300 patients, about 65 percent of total capacity. They employed almost 7,100 full-time persons, including 630 doctors. Table I gives a breakdown of these main facts by agency and the relative location of the individual hospitals is shown on the map on the next page.

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# FEDERAL HOSPITALS IN NEW YORK AREA JUNE 30, 1948

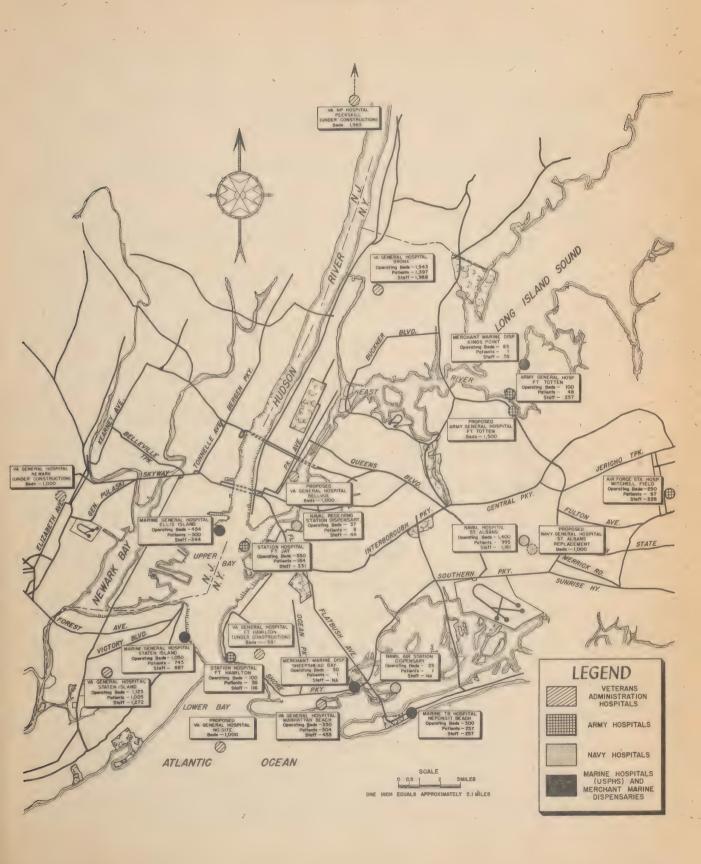




Table I

HOSPITAL FACILITIES OF MAJOR FEDERAL AGENCIES - NEW YORK AREA

June 30, 1948

| Agency                  |       | Capacity<br>Operating | Patients | - Empl | -Time<br>oyees |
|-------------------------|-------|-----------------------|----------|--------|----------------|
| POTAL                   | 8,257 | 6,949                 | 5,330    | 7,053  | 630            |
| Veterans Administration |       | 3,018                 | 2,706    | 3,695  | 334            |
| Public Health Service   | 1,554 | 1,804                 | 1,302    | 1,488  | 132            |
| Navy                    | 2,112 | 1,500                 | 987      | 1,100  | 104            |
| Army and Air Force      | 1,021 | . 627                 | 335      | 770    | 60             |
|                         |       |                       |          |        |                |

In general, except for the Army and Air Force station and general hospitals, the federal hospitals in the New York City area are adequately staffed and equipped to provide a good quality of general hospital care.

## Public Health Service

pital operated by the Public Health Service. All are constructed of permanent materials and in combination have a total capacity of 1,550 beds. At the time of survey enough expansion beds were in use to bring the total operating capacity to 1,800 beds accommodating 1,300 patients. The 132 full-time physicians on duty included qualified specialists, residents, and interns. A good training program is in operation with consultants from the faculties of the New York

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City medical schools. The occupancy rate of these hospitals could be increased if more full-time physicians and supporting personnel were available. The detail by individual hospital is shown in Table IV.

The Neponsit Beach hospital is owned by New York State and is being used temporarily by the Public Health Service for tuberculous patients. The hospital at Ellis Island is the neuropsychiatric center for the Public Health Service in the New York City area, but it also has a general medical service. Immigrants in need of medical attention are treated at Ellis Island, on a reimbursable basis, for the Immigration Service. All of the general surgery for the New York City area is concentrated at the Staten Island Hospital.

At the time of survey the Public Health Service hospitals were 86, 71, and 66 percent occupied, if operating capacity is used as a base. Of the 1,300 patients in hospital, 89 percent were merchant seamen or other primary beneficiaries of the Public Health Service, less than one percent were veterans, about one percent were dependents, and other miscellaneous contingent beneficiaries accounted for the remaining nine percent.

## Veterans Administration

There are three Veterans Administration general hospitals of permanent or semi-permanent construction in excellent condition. Together they have a total capacity of 3,570 beds, an operating capacity of 3,020 beds, and a patient-census of 2,710. The full-time staff of 3,700 employees includes 334 doctors, among them 189 residents and interns. These hospitals provide medical care of excellent quality. The full-time staff includes well-qualified specialists and part-time consultants

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from the faculties of the New York City medical schools. The appendix gives the detail for each hospital.

The Veterans Administration hospital at Staten Island belongs to New York State and is leased to the Veterans Administration. There are at present no plans for its return to New York State, although this may be done in the future. The Veterans Administration hospital at Manhattan Beach belongs to the Public Health Service and is scheduled to revert to that agency by December 31, 1950. A Veterans Administration hospital of 981 beds now under construction at Fort Hamilton will replace Manhattan Beach in the Veterans Administration system. In addition the Veterans Administration proposes to build two 1,000-bed general hospitals in New York City, making a net addition of 2,600 beds to its present system.

At the end of June the three hospitals had occupancy ratios of 84, 67, and 76 precent. Three-quarters of all the patients were veterans whose conditions were nonservice-connected.

## Navy

The St. Albans Navy Hospital is located about 18 miles from the Brooklyn Navy Yard and is from eight to 18 miles from the Army and Air Force installations in the area. It was completed in 1942 and is of temporary construction. The Navy plans to replace it with a permanent, 1,000-bed general hospital. Although the total capacity is 2,112, only 1,500 beds are staffed for operation, and there were only 987 patients at the time of survey, or 47 percent of total capacity and 66 percent of operating capacity. Its staff of 1,161 full-time employees includes

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 104 physicians of whom 58 are residents and interns. Of the 104 full-time physicians five are specialists in obstetrics and gynecology and two in pediatrics. The quality of medical care is good, there being an adequate number of specialists and an active group of part-time consultants from the New York City medical schools. Further details are given in the appendix.

The patient census of 987 at the time of survey subdivides into 62 percent active-duty personnel, two percent veterans with service-connected conditions, 21 percent veterans with nonservice-connected conditions, three percent dependents, and 12 percent other supernumeraries.

#### Army

There is an Air Force station hospital at Mitchell Field and three Army hospitals within New York City itself, one of which (at Fort Totten) is a small general hospital. All have some permanent and some temporary construction, and their total capacity is 1,021 beds. At the time of survey 627 beds were staffed for operation and 335 patients were in hospital. Their total full-time staff comprises 770 persons, of whom 60 are physicians. There are no residents or interns. Few of the 50-odd part-time physicians attached to these hospitals are active. Although there are a few full-time specialists in some fields of medicine, their distribution and type are inadequate to provide a uniformly good quality of service. The Fort Totten general hospital is the Army center for obstetrics in the New York area, and has two full-time and two part-time specialists in this field. The Ft. Hamilton station hospital is the Army center for

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pediatrics, but its only qualified pediatrician is part-time, whereas Fort Totten has one full-time and two part-time specialists in pediatrics, and St. Albans has two full-time and two part-time. At the time of survey 35 of the 36 patients at the Fort Hamilton hospital were dependent children.

It should also be noted that the Army plans to replace the present hospital at Fort Totten with a permanent 1,500-bed general hospital.

Study of the patient-population of the Army and Air Force hospitals shows that 335 inpatients consisted of 72 percent active-duty personnel and 28 percent dependents.

## Analysis

Once one adopts the point of view of the federal government rather than that of a single agency, and visualizes the federal hospitals in an area as a unified system, it becomes plain that the facilities and personnel in the New York City area are not being efficiently used, especially by the armed forces. The Navy maintains at St. Albans a credit of 400 beds for Veterans Administration patients, which exceeds the total inpatient population of the four army and Air Force hospitals, and its own inpatients represent only 47 percent of its total and 66 percent of its operating capacity. If all the Army and Air Force patients were placed in St. Albans, only 88 percent of its operating capacity would be occupied. Yet St. Albans held 226 Veterans Administration patients at the time of survey, in the face of 860 empty beds in Veterans Administration hospitals. Moreover, St. Albans is centrally located among the military installations. If the Army and

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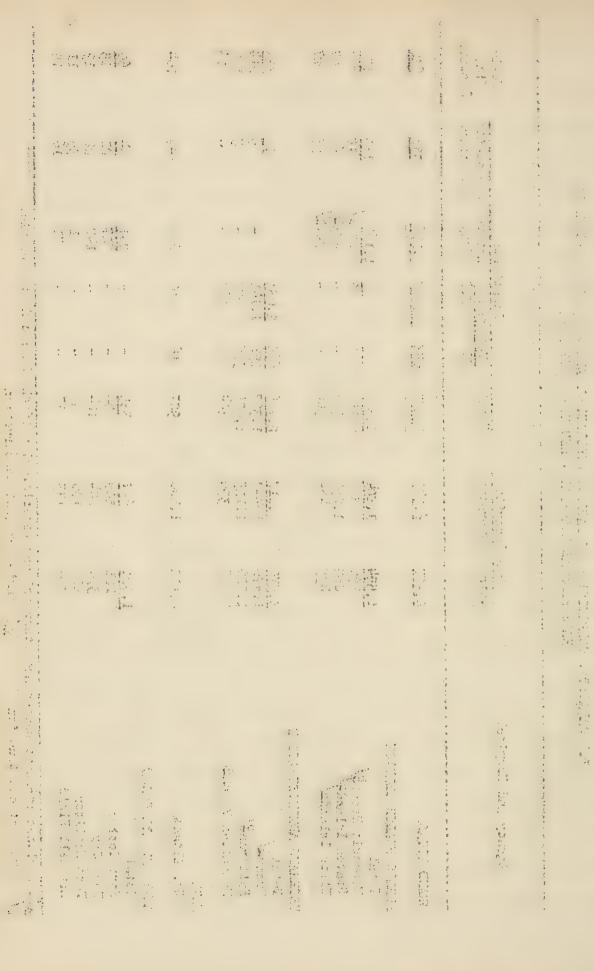
Table II

BED CAPACITY, COMPOSITION OF PATIENT POPULATION, AND FULL-TIME DOCTORS FOR EACH FEDERAL HOSPITAL - NEW YORK CITY AREA

| Full-<br>Time<br>Doctors | 630         | 29 28   | 334<br>214<br>104<br>16   | 101                | 112  |
|--------------------------|-------------|---|---|--------------------|--|
| Dependents<br>and Others | 386         | 23 62 83  | 0 10.10.1   | 149                | 122 22 1<br>123 22 1   |
| ents<br>Active<br>Duty   | 2.016       | 1,163<br>233a/<br>683a/<br>247a/  | į t t   | 612                | 241<br>142<br>1 142  |
| Inpatients Veterans Act  | 2,245       | म्म । ।   | 2,031<br>1,141<br>622<br>268  | 210                |  |
| Vete                     | 683         | 01011   | 665<br>251<br>378<br>36   | 16                 | 1 1 1 1  |
| Total                    | 5.330       | 2557 745  | 2,706<br>1,397<br>1,005   | 126                | 335<br>164<br>36<br>87   |
| Capacity<br>Operating    | 6,949       | 1,804   | 3,018<br>1,543<br>1,125   | 1,500              | 627<br>100<br>284<br>100<br>143  |
| Bed<br>Total             | 8,257       | 1,554<br>869<br>435   | 3,570<br>1,670<br>1,500   | 2,112              | 1,021<br>121<br>350<br>300<br>250  |
| Agency and Hospital      | GRAND TOTAL | PUBLIC HEALTH SERVICE Total Neponsit Beachby Staten Islandby Ellis Islandby | VETERANS ADMINISTRATION Total Bronx b/ Halloran b/ Manhattan Beach C/ | NAVY<br>St. Albans | ARMY AND AIR FORCE Total Fort Totten Fort Jay Fort Hamilton Mitchell Field |

Includes merchant seamen and other primary beneficiaries of the Public Health Service Semi-permanent construction Permanent construction बिक्र

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Air Force can transport some of its pediatrics cases 20 miles in one direction, and some of its obstetrics cases 20 miles in another, it would appear feasible to transport Army and Air Force personnel to the centrally located Navy hospital. Were this step taken, outpatient dispensaries could replace the four Army and Air Force hospitals, at a considerable financial saving. Perhaps of greater importance is the economy which would be effected in the utilization of scarce medical personnel. The 60 full-time physicians now staffing the Army and Air Force hospitals could be reduced to perhaps ten, permitting a saving of possibly 50 doctors, and the Army and Air Force patients would receive much better care. Some of the 50 doctors released from the four hospitals might be required at St. Albans if it continued to care for as many as 226 veteran patients and its 149 other supernumeraries, but there is no reason why some of these veterans could not be cared for by the Veterans Administration or by the Public Health Service. Once flexible arrangements of this type were regarded as possible, it is believed that the remaining federal hospitals could absorb the 335 military patients without requiring additional personnel.

Further, if one examines the composition of the patient-census of the military hospitals it becomes even more apparent that most or all of the army and Air Force hospitals should be regarded as surplus under present military conditions in the area, for four hospitals are being operated to care for only 241 active-duty personnel, while a fifth cares for 226 Veterans Administration patients and 149 dependents and other supernumeraries and still operates far below its staffed

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capacity. The total number of active-duty military personnel in hospital in the area is only 853, or 57 percent of the operating capacity of St. Albans.

It is not only the military hospitals which are caring for a high proportion of contingent beneficiaries (35 percent). It is even more characteristic of the Veterans Administration hospitals.

Only 25 percent of the patients in the three Veterans Administration hospitals have service-connected illnesses, the rest having conditions common in civilian life and judged unrelated to their military service. Thus the Veterans Administration is operating a hospital plant of 3,570 beds for about 680 primary beneficiearies. By placing some of its cases in the Navy hospital at St. Albans it contributes to the inefficient use of doctors in military service, as shown above.

On this basis, there is no reason why absorption of the Army and Air Force patients by St. Albans should require the use of any additional Army and Air Force physicians at all, for the Veterans Administration can easily reduce its inpatient load to the capacity of its own hospitals at any time.

Taking an over-all federal point of view, therefore, one must recognize that a 8,260-bed federal plant is being maintained to care for about 2,700 primary beneficiaries; 683 are veterans with illness connected with their military service; 853 are military personnel; and 1,163 are merchant seamen and other primary beneficiaries of the Public Health Service. On this basis the plant is less than half full of primary federal beneficiaries. If one takes only the hospitals of permanent construction, omitting Neponsit Beach which is

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to be returned to New York City, one finds a total permanent capacity of 4,900 beds. This neglects St. Albans, built in 1942 as a temporary hospital, and actually still in excellent condition, but includes Halloran because no plans have been made to return it to New York State. In addition, the Veterans Administration already has under construction in Brooklyn a general hospital of 981 beds and two more are planned. The Army plans a permanent 1,500-bed general hospital at Fort Totten, and the Navy a 1,000-bed hospital at St. Albans. This makes a projected addition of 5,500 permanent beds at a cost of \$105 million. Omitted from this projection are two Veterans Administration hospitals under construction in nearby Newark and Peekskill. Thus it is proposed to more than double the permanent federal plant in the New York City area, although the present plant is less than 60 percent occupied. Even if one were to forecast that by 1955 the needs of veterans with service-connected illness would double, and that by 1955 military personnel would double, and then discount the Army hospital at Fort Totten on the basis that its patients would be drawn from Army station hospitals outside the immediate New York City area, the total clear federal obligation to provide direct care within the area would be for less than 4,400 patients, well within the present total of 4,900 permanent beds, and only half the projected total of about 8,800 permanent beds. Thus, even after excluding Fort Totten, one can explain the increase of 80 percent only as an expansion undertaken in the interests of contingent beneficiaries, notably veterans with no service-connected need for hospitalization.

Aside from the financial extravagance of this expansive federal hospital program, little if any consideration has apparently been given to the great problem of physician-personnel staffing that it would raise. Real difficulty is now being encountered in staffing the federal hospital system. Yet in the New York City area alone a hospital construction program has been formulated which would more than double present requirements for physicians. Although it has become increasingly apparent that the federal hospital system has already expanded beyond its available manpower resources, efforts are still being directed toward its further expansion. Obviously this kind of federal hospital programming can only accentuate the imbalance which now exists between the supply of physicians for federal medical service and the burden of federal medical care. Rather than moving in a direction designed to solve the problem of shortage of physicians for federal medical service, the federal government by these actions is moving in a direction designed to aggravate the problem.

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Table III

FEDERAL HOSPITAL CONSTRUCTION PROGRAM IN NEW YORK CITY
June 30, 1948

| Agency and Location                                    | Bed<br>Capacity         | Estimated Cost of<br>New Construction<br>(in Millions) |
|--|-------------------------|--|
| GRAND TOTAL  | 10,355                  | \$105,2  |
|  | A. ALREADY IN OPERATION |  |
| Total  | 4,874                   |  |
| Veterans Administration Bronx Halloran Manhattan Beach | 1,670<br>1,500<br>400   |  |
| Public Health Service<br>Staten Island<br>Ellis Island | 869<br>435              |  |
|  | B. UNDER CONSTRUCTION   |  |
| Veterans Administration<br>Brooklyn                    | 981                     | \$ 19.4  |
|  | C. PROPOSED             |  |
| Total  | 4,500                   | \$ 85.8  |
| Veterans Administration New York City New York City    | 1,000<br>1,000          | 23.2<br>22.6   |
| Army Ft. Totten  | 1,500                   | 25.0   |
| Navy<br>St. Albans                                     | 1,000                   | 15.0   |

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Table IV

MAJOR REDERAL HOSPITALS IN NEW YORK CITY AREA

| Item  | Public He<br>Neponsit<br>Beacha | Health Serv<br>Staten<br>Island | Service<br>n Ellis<br>d Island              | Veterans<br>Bronx Ha             | Administ<br>11oran         | Manhattan<br>Beach |
|---|---------------------------------|---------------------------------|---|----------------------------------|----------------------------|--------------------|
| BEDS<br>Total Capacity<br>Operating   | 250                             | 1,050                           | 432<br>454                                  | 1,670                            | 1,500                      | 1400               |
| PATIENTS IN HOSPITAL  | 257                             | 745                             | 300   | 1,397                            | 1,005                      | 304                |
| PERCENT OCCUPANCY OF TOTAL CAPACITY   | 1598                            | 716                             | 7599  | ή8                               | 19                         | 16                 |
| OUTPATIENT CLINIC   | уев                             | A es                            | yes   | Yes                              | Aes                        | yes                |
| Total Personnel Total Full-Time Doctors Residents and Interns Staff Doctors Part-Time Doctors Ouglified Full-Time Doctors | 257<br>8<br>8<br>6              | 887<br>727<br>35<br>468         | 34th 22 22 22 22 22 22 22 22 22 22 22 22 22 | 1,968<br>214<br>130<br>84<br>130 | 1,272<br>104<br>559<br>445 | 172                |
| MEDICAL SCHOOL AFFILIATION  | none                            | none                            | no  | S O                              | none                       | none               |
| TYPE OF CONSTRUCTION  | Permanent                       | Permanent                       | Permanent                                   | Permanent                        | Permanent                  | t Semi-            |

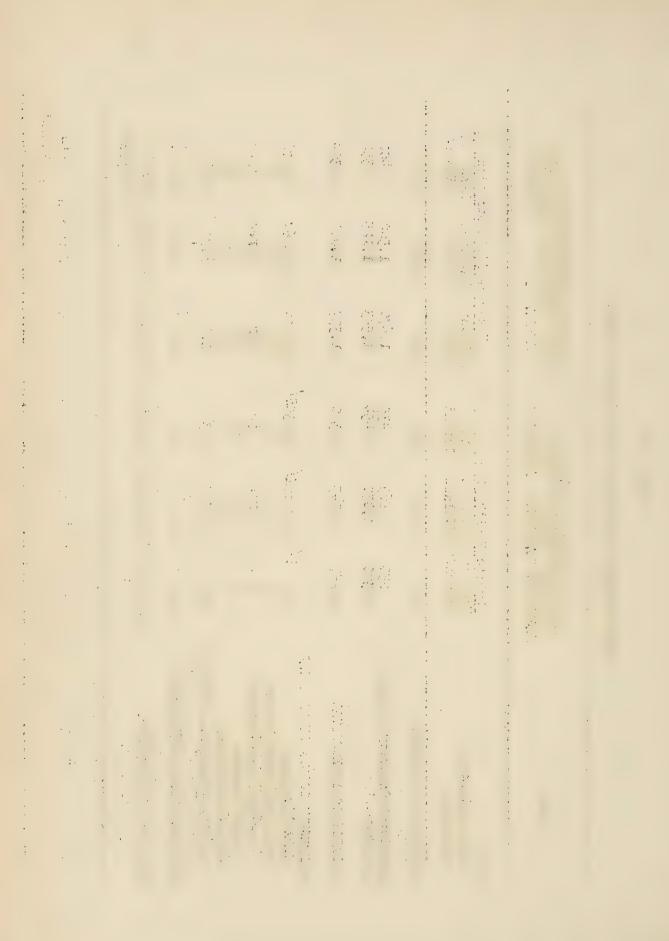


Table IV (Continued)

MAJOR FEDERAL HOSPITALS IN NEW YORK CITY AREA

| 10.   |   | 7   | 21 TO   |  | 1  |
|---|---|---|---|--|--|
|   | St. Albans Hospital                           | Fort<br>Totten  | Fort Hami                                       | Fort Mi                                  | Mitchell<br>Field  |
| BEDS Total Capacity Operating   | 2,112   | 121   | 350<br>284                                      | 300                                      | 250  |
| PATIENTS IN HOSPITAL  | 126   | 143   | 164   | 36                                       | 87   |
| PERCENT OCCUPANCY OF TOTAL CAPACITY   | Lt II   | 017   | 241   | 12                                       | 35   |
| OUTPATIENT CLINIC   | yes   | yes   | No.   | Ves                                      | yes  |
| PERSONNEL Total Personnel Total Full-Time Doctors Residents and Interns Staff Doctors Part-Time Doctors Qualified Full-Time Doctors VEDICAL SCHOOL AFFILIATION TYPE OF CONSTRUCTION | 1,161<br>104<br>58<br>46<br>41<br>yes<br>none | 170<br>15<br>-<br>15<br>23<br>yes<br>none<br>Permanent &<br>Temporary | 331<br>19<br>25<br>yes<br>none r<br>Permanent i | 130 11 11 11 no Permanent & ry Temporary | 139<br>15<br>15<br>6<br>yes<br>none<br>tt & Permanent<br>ary & Temporary |

To be returned to New York City and replaced by Manhattan Beach (to be returned to Public Health कि

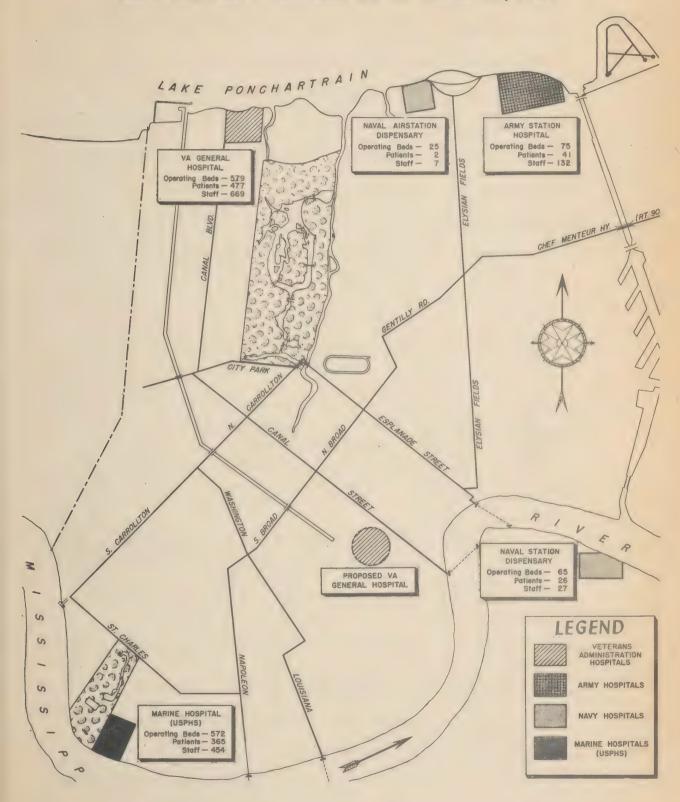
Service by Veterans Administration). To be returned to Public Health Service as replacement for Neponsit Beach and to be replaced by c/ Percentage occupancy of operating capacity. new hospital at Fort Hamilton P

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### FEDERAL HOSPITALS IN THE NEW ORLEANS AREA

EXISTING AND PROPOSED AS OF JUNE 30, 1948





#### NEW ORLEANS AREA

There are five federal hospitals within a radius of five or six miles of the center of New Orleans, with a combined capacity of 1,620 beds. At the time of survey only 1,278 beds were staffed for operation, and 913 patients were in hospital. There were more than 1,200 full-time employees, including 106 doctors. Table V gives these figures for each agency. All are completely equipped to give good care, although the military hospitals are equipped as station hospitals and the others as general hospitals.

Table V

HOSPITAL FACILITIES OF MAJOR FEDERAL AGENCIES - NEW ORLEANS AREA
June 30, 1948

| Agency                                      |                   | Capacity Operating | Patients        | Full-time<br>Total | Employees<br>Doctors |
|---|-------------------|--------------------|-----------------|--------------------|----------------------|
| TOTAL                                       | 1,620             | 1,278              | 913             | <u>NA</u>          | 106                  |
| Veterans<br>Administration<br>Public Health | 670               | 579                | 477             | 620                | 53                   |
| Service<br>Navy<br>Army                     | 500<br>250<br>200 | 572<br>52<br>75    | 365<br>30<br>41 | 430<br>NA<br>132   | 41<br>6<br>6         |
|   |                   |                    |                 |                    |                      |

#### NA not available

Two Navy hospitals are called dispensaries, but are true station hospitals according to the generally accepted definition and comparable to the Army station hospital. The attached map gives their individual location.

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Public Health Service The Marine Hospital is in permanent buildings and is well-staffed professionally. It is affiliated with one of the local medical schools, has an active group of qualified part-time consultants, and is engaged in residency training and research. The quality of medical care is excellent. However, this hospital was only 64 percent occupied when visited, and almost half its patients were veterans.

Veterans Administration The Veterans Administration hospital in New Orleans is housed in temporary buildings taken over from the Navy after the war and is to be replaced by a permanent structure. The Veterans Administration hospital is affiliated with both local medical schools, has qualified specialists on its own staff, and has active, part-time consultants. It conducts a residency training program and some research. It provides medical care of excellent quality. On 30 June 1948 its patient-census amounted to 71 percent of total capacity and 82 percent of operating, but only 20 percent of operating, but only 20 percent of its patients were hospitalized for service-connected conditions. Additional details appear in Table VII.

Navy The two small Navy hospitals are of temporary construction, and only 52 beds of their total capacity of 250 is staffed for operation. Six physicians are assigned, only one of whom has board qualifications (in urology). There are no active consultants, no medical school affiliations, and no training programs. Even as station hospitals these hospitals are not adequately staffed professionally. Patients requiring general hospital care are sent

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to Navy general hospitals hundreds of miles away. When visited one hospital had 28 patients, the other two, which just about reflects the average for the fiscal year 1948 as a whole.

Army.

The Army station hospital at Camp Leroy Johnson is located

in temporary buildings and is much like the Navy hospitals in not being able to provide adequate medical care. That even such emergencies as acute appendicitis and gunshot wounds are not managed well by the present staff is illustrated by two case histories, one involving death, with the details of which the committee member making the survey is thoroughy familiar.

Patients considered to require general hospital care are transferred to Army general hospitals in San Antonio, Hot Springs, etc. At the time of survey the hospital held only 41 patients.

Analysis The key to the New Orleans situation, from the overall federal point of view, is furnished by the Marine Hospital.

It reserves a credit of 175 beds for veterans while the total military requirement of the area, being met by three small, poorlystaffed hospitals, is about half this amount. Moreover, only 11

percent of the 160 veterans in the Marine Hospital on 30 June, 1948

were there for service-connected conditions.

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Table VI

BED CAPACITY, COMPOSITION OF PATIENT POPULATION, AND FULL-TIME DOCTORS, FOR EACH FEDERAL HOSPITAL, NEW ORLEANS AREA June 30, 1948

| Agency & Hospital                      |            | d Capacity<br>Operating | Canada Ca |      | ntients<br>cerans<br>NSC | Other | Full<br>Time<br>Doctors |
|--|------------|-------------------------|--|------|--------------------------|-------|-------------------------|
| TOTAL                                  | 1,620      | 1,278                   | 913  | 112  | 523                      | 278   | 106                     |
| NAVY<br>Navy Station<br>Air Station    | 150<br>100 | 27<br>25                | 28 2   |      | -                        | 28    | 4 2                     |
| ARMY<br>Station Hospital               | 200        | 75                      | 41   | uqu. | -                        | 41    | 6                       |
| PUBLIC HEALTH SERV                     | ICE<br>500 | 572                     | 365  | 17   | 143                      | 205   | 41                      |
| VETERANS ADMINISTR<br>General Hospital |            | 579                     | 477  | 95   | 380                      | 2     | 53                      |

In other words, the armed forces keep open three small hospitals and detail 12 doctors to posts which might be served by three or four on a dispensary (outpatient) basis, when there is an excellent Marine hospital with ample bed-capacity above and beyond its present patient-census. Moreover, the gains which would accrue from the consolidation of federal hospitals in the area are not limited to the saving of a few physicians. Equally if not more important is the fact that in the area armed forces personnel who may be classified as primary beneficiaries are not receiving the best medical care available in federal hospitals, whereas veterans with

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nonservice connected illnesses, dependents, and the like who may be classified as contingent beneficiaries are receiving this high quality care.

Finally, the proportion of hospitalized veterans whose conditions are nonservice-connected is high not only in the Marine hospital (89 percent) but also in the Veterans Administration hospital itself. On 30 June 1948, 80 percent of the inpatients there had nonservice-connected complaints. Thus at the present time a hospital plant of about 1,600 beds is being maintained in the presence of somewhat less than 400 primary beneficiaries.

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Table VII

HOSPITALS OF FEDERAL AGENCIES IN THE NEW ORLEANS AREA
June 1948

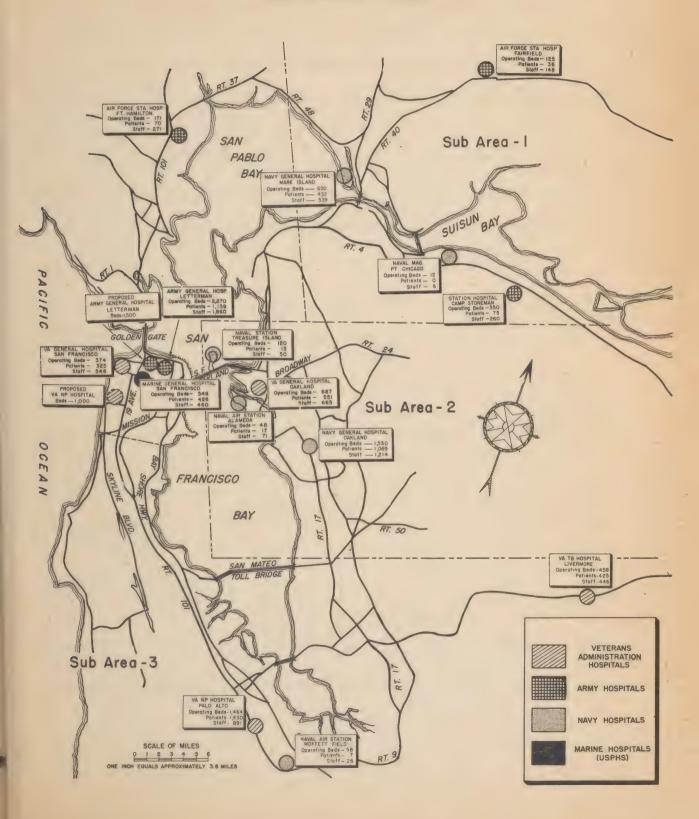
| Item   | Navy<br>Station | Air              | Army<br>Station<br>Hospital |                                    | VA<br>eneral<br>ospital            |
|--|-----------------|------------------|-----------------------------|------------------------------------|------------------------------------|
| BEDS Total Capacity Operating  | 150<br>27       | 100<br>25        | 200<br>75                   | 500<br>572                         | 670<br>579                         |
| PATIENTS IN HOSPITAL   | 28              | 2                | 41                          | 365                                | 477                                |
| PERCENT OCCUPANCY OF<br>TOTAL CAPACITY   | 19              | 2                | 20                          | 64                                 | 71                                 |
| OUTPATIENT CLINIC  | yes             | yes              | yes                         | yes                                | yes                                |
| PERSONNEL Total Personnel Total Full-Time Doctor Residents and Inter Staff Doctors Part-Time Doctors Qualified Full-time Doctors |                 | 2<br>-<br>2<br>- | 128<br>6<br>-<br>6<br>1     | 430<br>41<br>24<br>17<br>24<br>yes | 620<br>53<br>39<br>14<br>32<br>yes |
| MEDICAL SCHOOL AFFILIA   | TION no         | no               | no                          | yes                                | yes                                |
| TYPE OF CONSTRUCTION   | Temporary       | Temporary        | y Tempora                   | ry Permanen                        | t Temp.                            |

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# FEDERAL HOSPITALS IN THE SAN FRANCISCO AREA

SEPTEMBER 1948





#### SAN FRANCISCO AREA

There are 15 major federal hospitals in the San Francisco area with a total capacity of about 11,800 beds and four minor dispensaries (Navy) which are excluded from this survey. At the time of the survey their operating capacity was almost 8,900 beds and their combined patient-census 6,035. There were 7,455 full-time employees, including 532 physicians. Table VIII gives these facts for each agency, the attached map shows the location of the individual hospitals and Table X carries detailed data for each hospital.

Table VIII

HOSPITAL FACILITIES OF MAJOR FEDERAL AGENCIES, SAN FRANCISCO AREA

September 30; 1948

| Agency                       | Bed Control | apacity Operating | Patients |       | Employees<br>Doctors |
|------------------------------|-------------|-------------------|----------|-------|----------------------|
| TOTAL                        | 11,827      | 8,885             | 6,035    | 7,455 | 532                  |
| Veterans Admin-<br>istration | 3,118       | 2,983             | 2,731    | 2,550 | 185                  |
| Public Health Service        | 500         | 548               | 426      | 460   | 38                   |
| Navy                         | 4,110       | 2,438             | 1,538    | 1,906 | 123                  |
| Army and Air Force           | 4,099       | 2,916             | 1,340    | 2,539 | 186                  |

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As is apparent there, the area covered by the survey was subdivided into three sub-areas, each (with a few exceptions) having a radius of eight to 12 miles. Except for the military station hospitals and two specialized Veterans Administration hospitals the federal hospitals in the San Francisco area are adequately staffed to provide a good quality of general hospital care.

#### Army and Air Force

There are four Army hospitals in the area, the major one being the Letterman General Hospital, a permanent hospital of 2,459 beds. There are also three station hospitals with 1,640 beds. The operating capacity of all four hospitals was 2,916 beds and the census of patients 1,340 on September 30, 1948. The occupancy ratios are: 47 percent at Letterman; seven percent at Stoneman; 15 percent at Hamilton; and 29 percent at Fairfield. Among the 2,539 full-time employees are 186 physicians. The staff of the Letterman General Hospital includes qualified full-time specialists as well as active part-time consultants from the faculties of local medical schools. A good residency program is being conducted. The professional staff at Camp Stoneman has the qualifications to provide good medical care of the station hospital type but at Fort Hamilton and at Fairfield the staffs have no special qualifications. At all the Army hospitals there is evidence of over-staffing.

The Army proposes to replace Letterman with a new 1,500-bed permanent hospital, and at Fairfield a new 150-bed permanent hospital is just being completed. At Camp Stoneman the local authorities state that a 500-bed, permanent hospital is being planned for completion in 1950.

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The composition of the patient-load in the Army and Air Force hospitals is as follows for the survey date: active duty personnel 66 percent; veterans 11 percent; dependents and others 23 percent. The bulk of the non-military inpatients are at Letterman, 151 veterans, 169 dependents, and 84 others, or 35 percent of the entire patient-census there. At the other hospitals, however, dependents constitute from one to two-thirds of the outpatient load.

#### Navy

The Navy has six major hospitals in the San Francisco area:

one large general hospital at Oakland, a smaller one at Mare Island,
and four station hospitals. With a total capacity of 4,110 beds,
these hospitals are staffed to operate 2,438 beds and have a patientcensus of 1,538, or 37 percent of total capacity and 63 percent of
operating capacity. For the individual hospitals the occupancy
ratios are 39 and 51 for the two general hospitals, and zero, seven,
nine, and ten for the small station hospitals.

The Oakland Naval Hospital is of temporary construction, and although it is without medical school affiliations it has qualified part-time and full-time specialists on its staff. The Mare Island Naval Hospital, which is of permanent construction, also has no medical school affiliation, and has a somewhat less well-qualified staff. It has no part-time specialists and only a few moderately well-qualified specialists on its full-time staff. Although it is designated as an amputation center it has no certified specialists in either plastic or orthopodic surgery. Most specialized surgical cases are transferred to Oakland.

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A CONTRACTOR SECTION

The Moffett Field Naval Hospital is a small but beautifully designed and well-equipped station hospital of permanent construction. The staff consists of four physicians without special qualifications. The station hospital at Port Chicago is also a well-built, permanent hospital but there are less than 150 Navy personnel on the post at present. At Treasure Island the hospital is of temporary construction. Although staffed for 120 beds its census was only 13 patients at survey. The station hospital at Alameda is a well-constructed, permanent hospital of 165 beds, staffed with seven physicians but having only 17 patients when visited.

Although only 37 percent of the total capacity of the Navy hospitals is occupied, almost half of the census consists of non-military patients. In all, 55 percent are active—duty Navy personnel, 32 percent veterans, eight percent dependents, and five percent other Navy supernumeraries. The Oakland Hospital alone held 370 veterans (67 percent with nonservice—connected conditions) or more than the entire census of active—duty and supernumerary (except veteran) patients of all the other Navy hospitals in the area. The number of non-veteran patients of all the hospitals is 1,040 or less than the present census of all patients at the Oakland Naval Hospital. At the Oakland and Mare Island Naval Hospitals it is estimated that dependents constitute from 80 to 95 percent of the outpatient load.

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#### Veterans Administration

There are four Veterans Administration hospitals in the area, one for tuberculosis at Livermore, one for neuropsychiatry at Palo Alto, and two general hospitals. Their combined capacity of 3,118 beds was staffed for 2,983 patients and held 2,731 when visited. The individual occupancy ratios are 70 and 82 for the general hospitals and 98 and 93 for the specialized. All are of permanent construction, and all have well-qualified specialists among both full-time and part-time physicians on their respective staffs. The neuropsychiatric hospital and the San Francisco General Hospital have close medical school affiliations and good residency programs. The tuberculosis hospital and the general hospital at Oakland have no teaching affiliations but give a good quality of care.

The Veterans idministration plans another 1,000-bed hospital for neuropsychiatric patients in the San Francisco area.

Analysis of the Veterans Administration patient load shows that about 1,100 of the 2,700 patients in hospital were there for service-connected conditions, the balance of almost 60 percent having only nonservice-connected complaints. By hospital the percentages for nonservice-connected conditions are 84 at Oakland, 77 at San Francisco, 59 at Livermore, and 46 at Pale Alto.

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#### Public Health Service

The Marine Hospital in San Francisco is of permanent construction with a total capacity of 500 beds. It is staffed to operate 548 beds and has a census of 426 or 85 percent of its total capacity. The staff of 38 full-time physicians includes well-qualified specialists and there are also 23 active part-time consultants from the faculty of the Stanford University Medical School. A good residency program is being conducted. An expansion-unit of 125 beds is being planned at an estimated cost of about \$4 million. Of the 426 patients in hospital at survey, \$4 percent were merchant seamen or other primary beneficiaries of the Public Health Service, 11 percent were veterans, and about one percent were dependents, and four percent other patients.

#### Analysis

Although the foregoing facts are broadly suggestive of marked changes in the utilization of federal hospital facilities in the San Francisco area if a federal point of view is adopted, an analysis by sub-area is even more convincing. In Table IX the station and general hospitals are grouped according to the sub-areas shown on the map, the two Veterans Administration specialized hospitals being excluded from the analysis at this point. Sub-area I includes four military hospitals with a total capacity of 2,104 beds and 56 doctors taking care of 340 active-duty patients, 128 veterans, and 75 dependents and other supernumeraries.

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Table IX

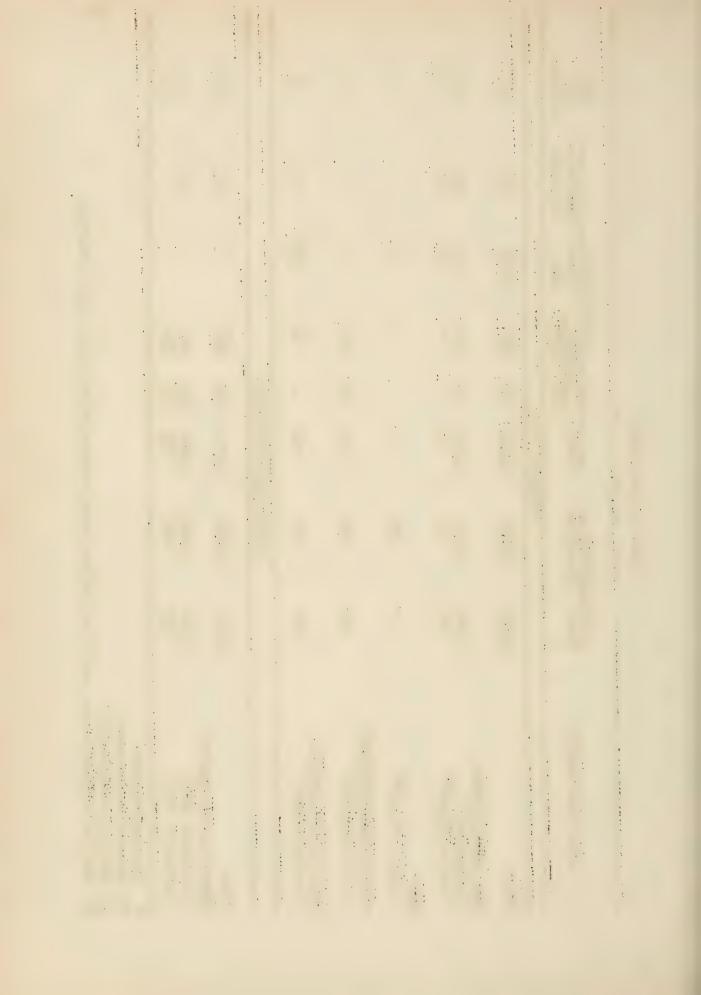
RED CAPACITY, COMPOSITION OF PATIENT POPULATION, AND FULL-TIME DOCTORS, FOR EACH FEDERAL HOSPITAL SAN FRANCISCO AREA

|   | m                              |             |          |       |                                     |  |          |       | 29  |  |
|---|--------------------------------|-------------|----------|-------|-------------------------------------|--|----------|-------|---|--|
|   | Full-<br>Time<br>Doctors       | 532         |          | 56    | 4 4                                 | 18   |          | 132   | 74  | 45   |
|   |                                |             |          |       |                                     |  |          |       |   |  |
|   | Dependents<br>and Others       | 532         |          | 72    | 29.1                                | 1-0  |          | 136   | 135   | Н  |
|   | 11,2                           | · ·         |          | 0     | 1 T                                 | o) io  |          | -+:   | ** <b>~ N</b>   | a debut and a selection of the selection |
|   | Active<br>Duty                 | 2,093       |          | 340   | 245                                 | 539  |          | 594   | 564   | Comme  |
|   | Inpatients Veterans Acti       | 2,137       |          | 11    | 111                                 | 1 1  |          | 602   | 247   | 1462   |
|   | Nete<br>SC*                    |             |          | 17    | 17                                  | 1 1  |          | 211   | 123   | 88   |
|   | Total                          | 6,035 1,273 | A I      | 班     | 432                                 | 36   | II Y     | 1,650 | 1,069   | 551  |
|   | :                              | 9           | SUB-AREA |       |                                     |  | SUB AREA |       | r#  |  |
|   | apacity<br>Operating           | 8,885       | Ω        | 1,137 | 12 650                              | 125  | ß        | 2,405 | 1,550<br>120  | 189  |
|   | Bed Capacity<br>Total Operatir |             |          | オ     | ЮÓ                                  | शक्  |          |       | 6 6 5<br>6 5 5<br>7 5<br>8 5 5<br>7 5<br>7 5<br>7 5<br>7 5<br>7 5<br>7 5<br>7 5<br>7 5<br>7 5 | 0  |
|   | Tota                           | 11,827      |          | 2,104 | 870                                 | 10,4   |          | 3,911 | 2,75  | 800  |
|   |                                |             |          |       |                                     |  |          |       |   | e Maria de Constantina de Constantin |
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|   | Hospi                          | ,           |          |       |                                     | ) RCE  |          |       | pur   | STRAT  |
| , | Agency and Hospital            | AL          |          |       | cagoa<br>landa                      | AIR F(   |          |       | e Isla  | ADMINI   |
|   | Agend                          | GRAND TOTAL |          | AL    | .VY<br>Pt. Chicagoa<br>Ware Islanda | ARMY and AIR FORCE<br>Fairfield<br>Camp Stoneman |          | AL    | VY<br>Oakland<br>Alamedaa/<br>Treasure Island   | VETERANS APMINISTRATION Oaklanda   |
|   |                                | GRA         |          | TOTAL | MAVY<br>Pt.                         | ARM  |          | TOTAL | NAVY<br>Oal<br>Al   | NET O  |

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Table IX (continued)

|   | Bed (       | apacity         |                |         | Inne                 | Invatients |                          | Full-      |
|---|-------------|-----------------|----------------|---------|----------------------|------------|--------------------------|------------|
| Agency and Hospital   | Total       | Total Operating | Total          | Vete    | Veterans<br>C* NSC** | Active     | Dependents<br>and Others | Time       |
|   |             | Str             | STE-AREA III   |         |                      |            |                          |            |
| TOTAL   | 3,890       | 3,421           | 1,987          | 111     | 1111                 | 1,159      | 306                      | 566        |
| AFMY and AIR FORCE<br>Lettermana/<br>Fort Hamiltona/  | 2,459       | 2,270           | 1,159          | 35      | 116                  | 755        | 253                      | 150        |
| NAVY<br>Moffett Fielda/   | 7.          | 250             | 7              | ŧ       | 1                    | 1          | 1                        | <b>a</b> t |
| VETERANS ADMINISTRATION<br>San Franciscos/  | 396         | 374             | 325            | 91      | 5/16                 | 1          | 1                        | 62         |
| PUBLIC HEALTH SERVICE<br>San Francisco <sup>2</sup> /   | 500         | 845             | 924            | 1       | 94                   | 3579       | 23                       | 38         |
|   |             | SPECIALIZED     | IZED HOSPITALS | TALS    |                      |            |                          |            |
| TOTAL CONTRACTOR SEC. CONTRACTOR  | 1,922       | 1,922           | 1,855          | 934     | 906                  | 1          | 12                       | 78         |
| Vermerans administration<br>Palo Alto NPa/<br>Livermore TBa/  | 1,464       | 1,464           | 1,430          | 761     | 656                  | 1 1        | 13                       | 62         |
| * Service-connected  ** Nonservice-connected  ** Permanent construction  D Includes merchant seamen and other primary beneficiaries of the Public Health Service. | and other p | rimary benefi   | icioni es      | f the E | Public E             | lealth Ser | vice.                    |            |



All the patients in the sub-area could easily be cared for at the permanent Navy general hospital on Mare Island, probably with little or no numerical increase in professional staff there, but preferably with some strengthening as to quality. If this were done, the other three hospitals could be closed in favor of dispensary (outpatient) services only, and a considerable proportion of the 56 physicians could be used elsewhere. Despite this, the Air Force is just completing a permanent 150-bed hospital at Fairfield and the Army talks of a permanent 500-bed hospital at Stoneman. The 85-bed permanent Navy hospital at Port Chicago, 12 miles from Mare Island, was finished in 1945, although it is now operating only 12 beds with virtually no patients. Moreover, if one considers the military hospital plant which would be required to care for military personnel in this sub-area, it is plain that even a doubling of military strength and patients would not require military facilities other than those at Mare Island. On the whole, with a few additions to the staff, a better quality of hospital care could be provided at Mare Island than in the station hospitals.

In <u>sub-area II</u> there are four federal hospitals located within a radius of about four or five miles, and having a total capacity of 3,911 bods and a census of 1,650 patients. In its three hospitals the Navy has 1,099 patients, less than 600 of whom are activeduty personnel, and 370 of whom are veterans. The Veterans Administration hospital has room for most or all of these veteran patients, since only 88 of its present census of 551 have service-connected conditions. Also, with only 30 patients in its

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two small hospitals the Navy can have no good reason for keeping them open. If military strength and patients were doubled, there would still be fewer military patients than the present operating capacity of the Oakland Naval Hospital. Patients hospitalized there would receive better medical care than in the small station hospitals. The total obligation of the Veterans Administration in the sub-area is 920 patients at the present time, of which only 23 percent represents patients with service-connected complaints. Even double the present number of patients with service-connected conditions would not utilize Veterans Administration facilities much beyond 50 percent in the foreseeable future.

In <u>sub-area III</u> all four federal agencies have hospital facilities with a total capacity of 3,890 beds and about 2,000 patients. Although Letterman General Hospital is old, it is very well staffed and could easily accommodate all the patients from Fort Hamilton and Poffett Field, giving a better quality of care to boot. What is more, the proposed permanent hospital of 1,500 with which the Army plans to replace the old Letterman hospital would be large enough to care for almost twice the number of military patients now found in this sub-area. The permanent 74-bed hospital at Moffett Field is a flagrant example of an unused federal hospital in an area of acute civilian need. It had seven patients when visited, and the average for the fiscal year was only 10.

If the two smaller military hospitals were closed and if Letterman were rebuilt and taken up with patients from a much larger military population, there would still be 900 permanent

federal beds in the area (in the Veterans Administration and Public Health Service hospitals) to care for what is now a firm federal obligation of less than 500 patients. Only 21 percent of the veteran patients have conditions classified by the Veterans Administration as service-connected. The present Veterans Administration general hospital can hold more than three times the number this represents. Also, the Public Health Service hospital now cares for 46 veterans, all with nonservice-connected conditions, without which it would have only 380 patients as against a total capacity of 500 beds. Yet an addition of 125 beds is planned for this hospital.

Although the survey revealed no evidence of under-staffing in the Navy hospitals, and although Army and Navy operate about the same number of both general and station hospital beds in the area, the patients-per-physician ratio is 12.5 for the Navy and 7.2 for the Army. It may be concluded that the Army is heavily over-staffed. This fact, taken in conjunction with savings which could be realized from consolidation of facilities, and from the exclusion of civilian patients (40 percent of the load) from military hospitals, casts grave doubts upon military requirements for doctors in the area.

A study of the hospital construction program provides further evidence of extravagant federal hospitalization planning. Among the 13 hospitals considered in this analysis, nine are permanent-type hospitals with a total capacity of 5,828 beds. The present total patient load for the entire 13 hospitals (including the three temporary-

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type hospitals) is only 4,180. Thus, with the entire patient load calculated against only the nine permanent hospitals with a capacity of 5,828 bods, the occupancy rate would be only 72 percent. Despite these facts plans are under way for the construction of three more permanent hospitals with a total capacity of 3,000 beds and an expansion unit of 125 bods for a total capacity of 3,125 bods at a cost of perhaps \$65 to \$75 million. Even with the replacement of Letterman by one of these hospitals and the closing of all presently employed temporary hospitals (with a combined capacity of 4,125 bods) this would provide a total of 6,494 bods in permanent-type hospitals. Including a 15 percent factor for dispersion, this would still provide hospitals in excess of present requirements of over 20 percent.

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Table X

HOSPITALS OF FEDERAL GOVERNMENT IN SAN FRANCISCO AREA
September 1948

| Item  | Naval Ho                      | Mare                  | Moffett        | Pt.            | Dispensari<br>Treasure |                |
|---|-------------------------------|-----------------------|----------------|----------------|------------------------|----------------|
|   | Oakland                       | Island                | Field          | Chicago        | Island                 | Alameda        |
| BEDS<br>Total Capacity<br>Operating   | 2,750 <sup>a</sup> /<br>1,550 | 840<br>650            | 74<br>58       | 85<br>12       | 196<br>120             | 165<br>48      |
| PATIENTS IN HOSPITAL  | 1,069                         | 432                   | 7              | ***            | 13                     | 17             |
| PERCENT OCCUPANCY OF<br>TOTAL CAPACITY  | 39                            | 51                    | 9              |                | 7                      | 10             |
| OUTPATIENT CLINIC   | yes                           | yes                   | yes            | yes            | yes                    | yes            |
| PERSONNEL Total Personnel Total Full-Time                                     | 1.214                         | 539                   | 26             | 6              | 50                     | 71             |
| Decters Residents & Inter Staff Doctors Part-Time Doctors Qualified Full-Time | 30<br>25                      | 31<br>2<br>29<br>none | 4 -            | 1 -            | 6                      | 7 7 4          |
| Doctors   | yes                           | yes                   | no             | no             | no                     | no             |
| MEDICAL SCHOOL<br>AFFILIATION   | none                          | none                  | none           | none           | none                   | none           |
| TYPE OF CONSTRUCTION  | Temp-<br>orary                | Perm-<br>anent        | Perm-<br>anent | Perm-<br>anent | Temp-<br>orary         | Perm-<br>anent |

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Table X (Continued)

HOSPITALS OF FEDERAL GOVERNMENT IN SAN FRANCISCO AREA
September 1948

|                                     | A                                | rmy                                  | Air Fo     | orce       |
|-------------------------------------|----------------------------------|--------------------------------------|------------|------------|
| Item                                | Letterman<br>General<br>Hospital | Camp Stoneman<br>Station<br>Hospital |            | Station    |
| BEDS                                |                                  |                                      |            |            |
| Total Capacity<br>Operating         | 2,459 2,270                      | 1,054                                | 461<br>171 | 125<br>125 |
| PATIENTS IN HOSPITA                 | L 1,159                          | 75                                   |            | 36         |
| PERCENT OCCUPANCY ( TOTAL CAPACITY  | OF 47                            | 7                                    | 15         | 29         |
| OUTPATIENT CLINIC                   | yes                              | yes                                  | yes        | yes        |
| PERSONNEL                           |                                  |                                      |            |            |
| Total Personnel Total Full-Time     | 1,860                            | 260                                  | 271        | 148        |
| Doctors Residents and               | 150                              | 18                                   | 12         | 6          |
| Interns                             | 96                               |                                      |            | -          |
| Staff Doctors                       | 54                               | 18                                   | 12         | 6          |
| Part-Time Doctors Qualified Full-T: | •                                | 9                                    | 3          | 2          |
| Docters                             | yes                              | yes                                  | no         | no         |
| MEDICAL SCHOOL<br>AFFILIATION       | none                             | none                                 | none       | none       |
| TYPE OF CONSTRUCTION                | ON perma-<br>nent                | temporary                            | permanent  | temporary  |

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Table X (Gontinued)

HOSPITALS OF FEDERAL GOVERNMENT IN SAN FRANCISCO AREA
September 1948

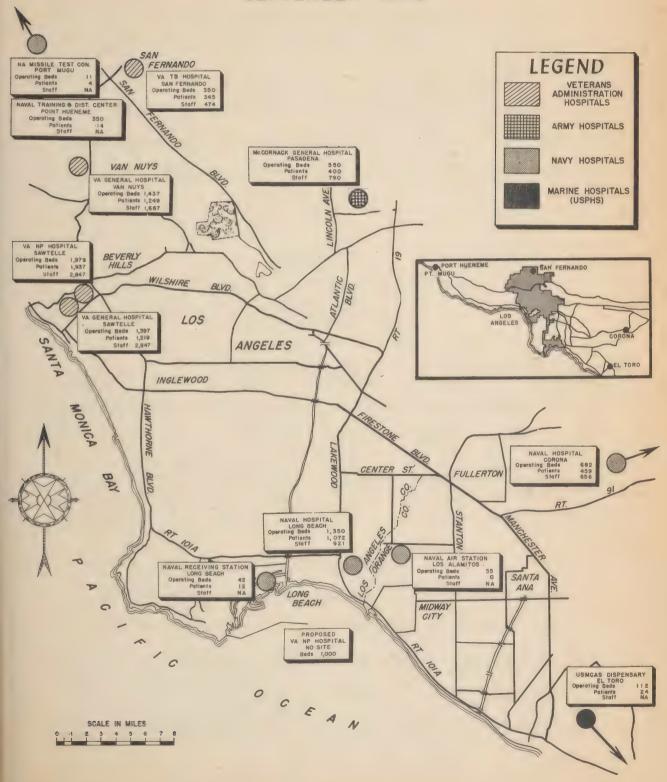
| Item                                      | PHS San Francisco General Hospital |            | rans Admini<br>n Francisco<br>General<br>Hospital | stration<br>Palo<br>Alto<br>NP | Liver-<br>more<br>TB |
|---|------------------------------------|------------|---|--------------------------------|----------------------|
| BEDS Total Capacity Operating             | 500<br>548                         | 800<br>687 | 396<br>374  | 1,464                          | 458<br>458           |
| PATIENTS IN HOSPITAI                      | 426                                | 551        | 325   | 1,430                          | 425                  |
| PERCENT OCCUPANCY OF<br>TOTAL CAPACITY    | 85                                 | 69         | 82  | 98                             | 93                   |
| OUTPATIENT CLINIC                         | yes                                | yes        | yes   | yes                            | yes                  |
| PERSONNEL Total Personnel Total Full-Time | 460                                | 665        | 548   | 891                            | 446                  |
| Doctors Residents and                     | 38                                 | 45         | 62  | 62                             | 16                   |
| Interns Staff Doctors Part-Time Doctors   | 27<br>11<br>23                     | 45<br>26   | 54<br>8<br>50                                     | 35<br>27<br>29                 | 16<br>16             |
| Qualified Full-Tim<br>Doctors             | yes                                | yes        | yes   | yes                            | yes                  |
| MEDICAL SCHOOL<br>AFFILIATION             | yes                                | none       | yes   | yes                            | none                 |
| TYPE OF CONSTRUCTION                      | permanent                          | permanent  | permanent   | perma-<br>nent                 | perma-<br>nent       |

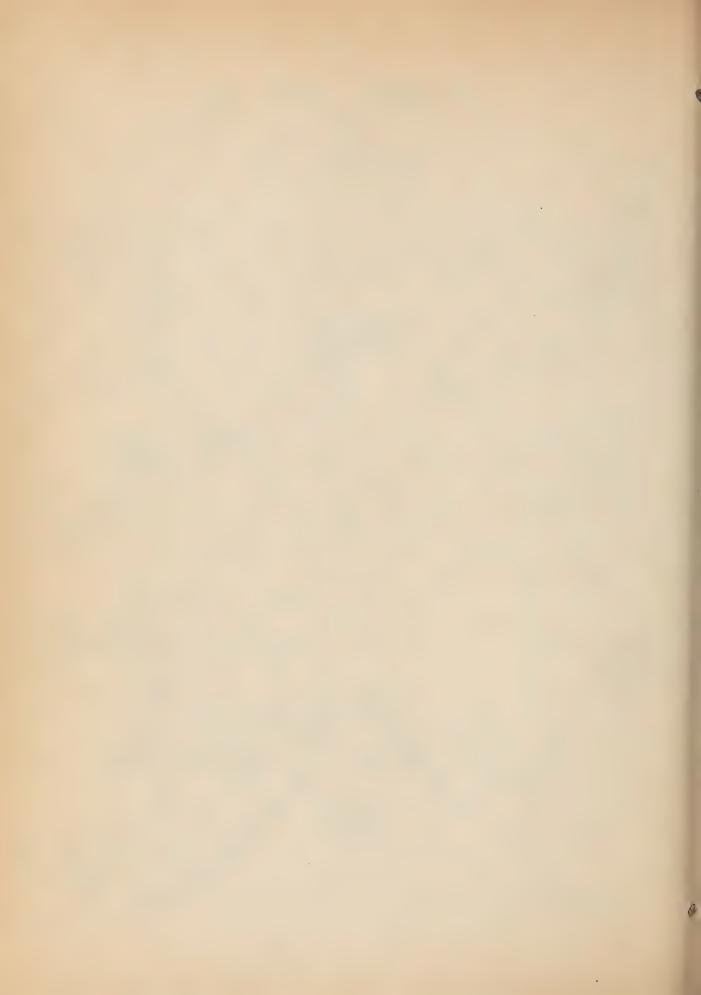
a/ A grand total of 6,600 beds might be available.

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# FEDERAL HOSPITALS IN LOS ANGELES AREA

SEPTEMBER 1948





### LOS ANGELES AREA

There are seven major federal hospitals in the Los Angeles area, all but one (at Corona) within a radius of 25 miles, with good transportation connections among them and with a total capacity of 10,791 beds. At the time of survey they were staffed to operate 7,745 beds and had 6,681 patients, or 62 percent of total capacity and 86 percent of operating. They employed about 7,350 persons, including 528 full-time doctors. Table XI gives these details by agency.

Table XI

HOSPITAL FACILITIES OF MAJOR FEDERAL AGENCIES,

LOS ÁNGELES AREA

September 1948

| Agency                                  |                       | apacity<br>Operating  | Patients              | Full-time<br>Total    | Employees<br>Doctors |
|---|-----------------------|-----------------------|-----------------------|-----------------------|----------------------|
| TOTAL                                   | 10,791                | 7,745                 | 6,681                 | 7,355                 | 528                  |
| Veterans Administration<br>Navy<br>Army | 5,562<br>4,654<br>575 | 5,163<br>2,032<br>550 | 4,750<br>1,531<br>400 | 4,988<br>1,577<br>790 | 381<br>111<br>36     |

### Veterans Administration

Four of the hospitals are operated by the Veterans Administration, two as specialized (neuropsychiatric and tuberculosis) hospitals and two as general medical and surgical hospitals. Both of the specialized hospitals are running at 90 percent of total capacity, have well-qualified staffs, and provide medical care of

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high quality. The two general hospitals are operating at 79 and 85 percent of total capacity and also have well-qualified medical staffs. Both are under the professional direction of deans committees appointed by local medical schools and furnish a high quality of medical care. A good residency program is being conducted in both hospitals. Staffing ratios differ markedly for the two hospitals, one having 9.5 and the other 7.4 patients per full-time doctor. A similar difference also applies to the respective consulting staffs. No striking differences in type of patient were noted, and it was the impression of the observer making this survey that one of the hospitals was somewhat ever-staffed. There is also a domicile at the Sawtelle Hospitals, with an additional five doctors and 2,900 patients at the time of survey. Further details are given in Table XIII.

On September 30 the four hospitals held 4,750 patients, of which 1,278 or 27 percent had service-connected conditions, 3,436 or 72 percent had nonservice-connected conditions, and the balance or less than one percent were non-veterans. The percentage of cases with nonservice-connected illnesses varied from 40 percent for the tuberculosis hospital at San Fornando to 91 percent at Madsworth. At Van Nuys the figure was 75 percent.

The Veterans Administration plans to construct another 1,000 bed hospital for the care of neuropsychiatric patients in the Los Angeles area at a cost of over \$21 million.

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### Army

The Army operates only one hospital in the Los Angeles area, the McCornack General Hospital at Pasadena. A converted resort hotel, this hospital has a total capacity of 575 beds, and had an operating capacity of 550 beds and 400 patients (70 percent of capacity) when visited. There were 36 full-time physicians on the staff, only one of whom was a qualified specialist (in internal medicine); two others may be qualified in another year. There are 23 part-time consultants who average about one visit per week. There is no affiliation with a medical school and there is no residency or teaching program. The quality of the professional staff needs considerable strengthening.

Of particular interest is the composition of the patient-load. Both the Public Health Service and the Veterans Administration have credits of 100 beds each at the hospital. At the time of survey the Public Health Service beds were about half filled and the Veterans Administration beds 85 percent occupied. There were 208 active-duty military personnel in hospital or about half the patient-census. The outpatient service is active and two-thirds of the outpatient visits are made by dependents, (17,409 of the total 26,257 outpatient clinic visits recorded for the six menths period, January to June, 1948, being for dependents).

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### Navy

The Navy has two large general hospitals in the area, one at Long Beach and one at Corona, as well as five smaller hospitals (termed dispensaries and having only 54 patients at the time of survey) at varying distances from the city. These are omitted from the detailed analysis, and are discussed later. The general hospitals have both permanent and temporary units. In relation to their combined permanent capacity of about 2,500 bods, the 1,531 patients represent a utilization of about 61 percent.

The Long Beach Naval Hospital has a total capacity of 1,790 beds, with 1,350 in operation, and a patient-census of 1,072. Construction planned for completion in 1950 will convert some of the temporary buildings into permanent, bringing the total to 1,800 beds in permanent buildings. This and other construction will cost about \$3.5 million. There is a credit of 350 beds for Voterans Administration patients, 150 beds are set aside for dependents, and Public Health Service patients are cared for as required. There are 92 full-time physicians on the staff, including 53 residents and interns, with 12 qualified specialists. The hospital has a formal affiliation with the University of Southern California to provide basic science training for its residents. The staff seems more than ample to care for the present patient-load. Only 48 percent of the patients are active-duty personnel, the remainder consisting of veterans (35 percent), dependents (10 percent), other supernumerary personnel and beneficiaries of the Public Health Service (seven percent).

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The Navy hospital at Corona is about 45 miles from the Long Beach Hospital and was formerly the lavish Norconian resort hotel, converted in 1941 at a cost of about \$14 million. There are three separate parts:

(1) the main general hospital of 1,263 beds (1,206 in a permanent building):

(2) a second unit with 600 temporary beds used as a tuber-

culosis hospital; and

(3) the third unit with 1,000 temporary beds now being used for cases of poliomyelitis and paraplegia.

There are 19 full-time physicians on the staff, nine of whom are qualified specialists. There is no residency or teaching program. At the time of survey there were 459 patients, 16 percent of total capacity and 38 percent of the capacity in permanent buildings. Only half of the patients are general medical and surgical problems, the rest being tuberculosis, poliomyelitis, and paraplegia cases. The hospital acts as a center for such patients, who are all long-term, and virtually none of whom will ever return to military duty. About 40 percent of these long-term patients are veterans, and there are more veterans than active-duty Navy personnel in the hospital. The percentage distribution of patients by type is: 37 percent active-duty Navy and Marine Corps; 39 percent veteran; one percent dependents; and 23 percent other supernumeraries of the Navy.

### Analysis

Three broad conclusions emerge from the foregoing factual material when one takes an over-all federal point of view. The first is that the Navy really does not need to operate Corona, for Long Beach is not nearly full, and transfer of some or all of the

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medical personnel at Corona to Long Beach would provide ample capacity for the present census of both hospitals. Actually, less than 700 active-duty personnel are presently in both hospitals combined, and if there were any question as to the capacity of the Long Beach Naval Hospital to care for the patients of both hospitals, it could easily be settled by dropping some of the 558 veterans, 500 of whom have nonservice-connected conditions.

Table XII

BED CAPACITY, COIPOSITION OF PATIENT POPULATION, AND FULL-TIME DOCTORS, FOR EACH FEDERAL HOSPITAL, LOS ANGELES AREA, September 30, 1948

|                                    |  |                     |              |            | Inpatie             | nts         |                               | ,                        |
|------------------------------------|--|---------------------|--------------|------------|---------------------|-------------|-------------------------------|--------------------------|
| Agency and<br>Hospital             | der miller belge biller miller miller belge miller | apacity<br>perating | Total        | Veter      | Character, editored | Active      | Depend-<br>ents and<br>Others | Full-<br>Time<br>Doctors |
| TOTAL                              | 10,791   | 7,745               | 6,681        | 1,344      | 4,013               | 890         | 434                           | 528                      |
| VETERANS ADMINISTRATI San Fernando | -  |                     |              |            |                     |             | **                            |                          |
| (TB) Van Nuys                      | 383<br>-1,590                                      | 350<br>1,437        | 345<br>1,249 | 197<br>296 | 137<br>935          | 6pts<br>800 | 11<br>18                      | 18<br>131                |
| Wadsworth<br>Brentwood             | 1,440  | 1,397               | 1,219        |            | 1,114               | -           | 5                             | 165                      |
| (NP)                               | 2,149  | 1,979               | 1,937        | 685        | 1,250               | 7           | 2                             | 67                       |
| ARMY<br>Pasadena                   | 575  | - 550               | 400          | 8          | : .: 77             | 208         | 107                           | 36                       |
| Long Beach<br>Corona               | 1,791<br>2,863                                     | 1,350               | 1,072        | 37<br>21   | 340<br>160          | 514<br>168  | 181                           | 92<br>19                 |

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The second broad conclusion is that even the Army patients in the McCornack General Hospital could be cared for at the Long Beach Hospital if it were decided that the military hospitals would be devoted primarily to military patients. Active-duty military personnel of all the armed forces amounted to only 890 patients in the three hospitals, less than the present patient-census at Long Beach and about half the proposed permanent capacity of the hospital.

The survey also included five smaller hospitals with a total capacity of 560 beds, staffed by 15 doctors, and having only 54 patients. Although one of these hospitals, at Pt. Hueneme, may be too far from Long Beach to warrant use of the latter in lieu of the facility at Pt. Hueneme, there seems little need for the others and it would appear that most of them could be closed in favor of outpatient services. The savings in doctors would be admittedly small, but better hospital care would be available to patients from these small posts, and some financial saving would result from closing the hospitals.

Finally, when one examines the Veterans Administration hospital capacity in the light of its firm obligation to provide care to veterans with service-connected conditions, one is impressed by the contrast between a hospital plant of about 5,600 beds and a census of only about 1,350 patients with service-connected conditions in the area. Moreover, another 1,000 beds are proposed in extension of this plant, making a projected total of 6,600 or about five times the firm obligation at the present time. Construction undertaken by

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the Veterans Administration in Los Angeles can be for only one purpose, the care of contingent beneficiaries.

The extravagance of this hospital construction program, when looked at from the federal government's point of view, is heightened further by the fact that the Army and Navy are now operating three hospitals when one could easily serve their total obligations for armed forces personnel even if these were doubled. If this were done the other two hospitals with a total capacity of over 3,000 beds (1,800 of which consist of permanent construction) could then more than meet the requirements of the Veterans Administration, thus eliminating entirely the need for construction of a new Veterans Administration hospital in this area.

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Table XIII

HOSPITALS OF THE FEDERAL GOVERNMENT IN THE LOS ANGELES AREA

September 1948

| Item                                      | Vete<br>San           | rans Ad              | Sawt                    | ation<br>elle<br>talsa/ | Army                    | Nava<br>Hospi  |        |
|---|-----------------------|----------------------|-------------------------|-------------------------|-------------------------|----------------|--------|
|   | Fern-<br>ando<br>(TB) | Van<br>Nuys<br>(GMS) | Wads-<br>worth<br>(GMS) | Brent-<br>wood<br>(NP)  | Pasadena<br>(McCornack) |                | Corona |
| BHDS                                      |                       |                      | . 111.0                 |                         |                         | . 701          |        |
| Total Capacity Operating                  | 383<br>350            | 1,590                | 1,440                   | 2,149                   | 575<br>550              | 1,791          | 682    |
| PATIENTS IN HOS-<br>PITAL                 | 345                   | 1,249                | 1,219                   | 1,937                   | 400                     | 1,072          | 459    |
| PERCENT OCCUPANCY<br>OF TOTAL CAPACITY    | 90                    | 79                   | 85                      | 90                      | 70                      | 60             | 16     |
| OUTPATIENT CLINIC                         | yes                   | yes                  | yes                     | no                      | yes                     | yes            | no     |
| PERSONNEL Total Personnel Total Full-Time | 474                   | 1,667                | 2,8                     | 47 <u>d</u> /           | 790                     | 921            | 656    |
| Doctors Residents and                     | 18                    | 131                  | 165                     | : 67                    | 36                      | 92             | 19     |
| Interns Staff Doctors Part-Time Doctor    | 18 s 12               | 80<br>51<br>50       | 116<br>49<br>63         | 30<br>37<br>16          | 36<br>23                | 53<br>39<br>29 | 19     |
| Qualified Full-<br>Time Doctors           | yes                   | yes                  | yes                     | yes                     | yesb/                   | Jee            | yes    |
| MEDICAL SCHOOL<br>AFFILIATION             | none                  | yes                  | yes                     | yes                     | none                    | nonec/         | none   |
| TYPE OF CONSTRUC-                         | perma-<br>nent        | - tempo              |                         | a- perma-               | - permanent             | permanent      | t and  |

In addition, the Veterans Administration operates a domicile at Sawtelle which had 2,898 patients on June 30, 1948.

b) Only one certified man on the staff, others will qualify for certification within the year.

Ed Basic science course for residents by contract with University of Southern California

These two hospitals are operated as part of one institution sharing certain personnel services.

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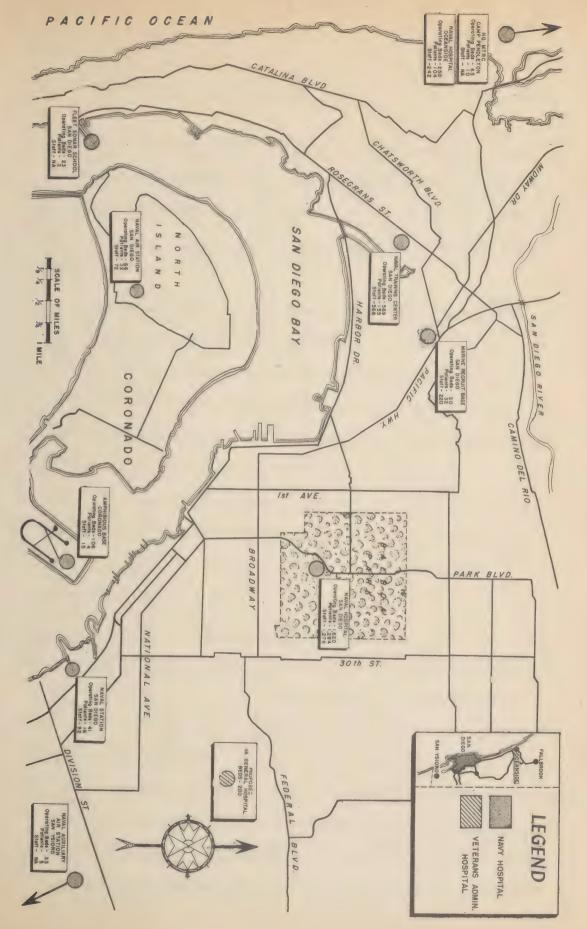
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# FEDERAL HOSPITALS IN SA SEPTEMBER, 1948 SAN DIEGO AREA





#### SAN DIEGO AREA

There are ten federal hospitals in and around San Diego, all Navy installations. The largest, the US Naval Hospital in San Diego, is centrally located, all but two hospitals being within about 15 miles. The latter are about 50 miles away near Oceanside.

Eight are classified as dispensaries by the Navy, although they conform to the standard definition of a station hospital and three of them each have a total capacity in excess of 200 beds. Excluding four of the smaller of these, which in all had about 40 patients at the time of survey, the total capacity was 4,534 beds, of which 2,661 were staffed for operation. At the time of this survey these hospitals employed about 2,400 full—time persons, of whom 148 were physicians. The patient—census of 1,600 represents 36 percent of capacity. The map gives the location of the individual hospitals.

#### San Diego Naval Hospital

This permanent hospital has a total capacity of 2,079 beds,

1,620 beds in operation, and 1,284 patients. Good temporary

buildings are available to provide an estimated emergency capacity

of more than 5,000 beds. The staff includes well-qualified specialists,

both full-time and part-time, and a residency program is in operation,

but there is no medical school affiliation. Most of the major

surgery for the San Diego naval area is performed at this hospital,

which also provides a considerable amount of specialized surgical

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and neurological treatment for malignant conditions.

The patient-census of the San Diego Naval Hospital may be analysed as follows: 69 percent active-duty Naval personnel; 15 percent veterans; nine percent dependents; and seven percent other supernumeraries. About 90 percent of the 186 veterans are hospitalized for nonservice-connected conditions.

#### Station Hospitals in San Diego

Four of the larger station hospitals are within five to ten miles of the San Diego Naval Hospital. All but one of these are of permanent construction, and a fifth of 41 beds, excluded because of its smaller size, is also of permanent construction. These four hospitals have a total capacity of 1,255 beds, an operating capacity of 791 beds, and 223 patients. There are 875 full-time employees, including 38 physicians who with 3 exceptions have no specialist qualifications. The hospital at the Naval Air Station actually consists of two hospitals about a mile apart, both having complete facilities and permanent construction. One is for military personnel and the other for dependents. The average occupancy rate for these hospitals is about 10 percent of constructed capacity. There are 10 full-time physicians on the staff (only one of whom is a specialist (in internal medicine) and five parttime fleet air medical officers assigned temporarily. Three physicians on the full-time staff are assigned to full-time administrative duties. The 692 bed hospital at the Naval Training Center with an average occupancy rate of less than 40 percent has 18

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full-time physicians, only 2 of whom are qualified specialist (in ophthalmology and preventive medicine). Two of these physicians are in administrative work exclusively. The 94 bed hospital at the Marine Recruiting Base, with an average occupancy rate of about 16 percent, has six full-time physicians on the staff, two of whom are assigned to administrative work. The 41-bed hospital at the Naval Receiving Station, with an average occupancy rate of 35 to 40 percent, has nine full-time physicians on the staff, three of whom (all of Captain grade) are in administrative work exclusively.

#### Oceanside Naval Hospital

About 50 miles from the San Diego Naval Hospital there is a Naval hospital of temporary construction with a total capacity of 1,200 beds. At time of survey 250 were staffed for operation and there were 104 inpatients. Thirteen full-time physicians are on the staff at Oceanside, five of whom are qualified specialists. In addition there are 11 medical officers attached to troops stationed at Camp Pendleton and who operate outpatient services independent of the hospital. Of 104 patients in hospital at the time of survey, 17 were dependents, and three were other supernumeraries.

#### Analysis

The maintenance of so many small hospitals within a short distance from a large, well-staffed general hospital represents an extreme dispersion of medical resources with resultant inefficiency in their utilization. The total number of patients in the area, veterans, dependents, and other supernumeraries included,

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amounts to just about the operating capacity of the one general hospital. With the possible exception of the patients at Oceanside and Camp Pendleton, all of the patients in the small hospitals could easily be accommodated at the general hospital (with little or no increase in its present staff) where they would receive a better quality of care. Outpatient dispensaries are surely needed at most or all of these smaller posts, but there is no need for them to have 50 or more doctors assigned to them.

Table XIV

BED CAPACITY, COMPOSITION OF PATIENT POPULATION, AND FULL-TIME DOCTORS, FOR NAVY HOSPITALS\*, SAN DIEGO AREA, SEPTEMBER 30, 1948

| Agency &<br>Hospital   | Bed Capacity Total Operating              |  | Inpatients Total Veterans Active Other SC NSC |        |     |                                   | Full-<br>Time<br>Doctors |                                |
|--|---|--|---|--------|-----|-----------------------------------|--------------------------|--------------------------------|
| TOTAL  | 4,534                                     | 2,661                                  | 1,611   | 21     | 165 | 1,199                             | 226                      | 148                            |
| San Diego<br>Oceanside<br>Training Center<br>Air Station<br>Recruiting Base<br>Amphibious Base | 2,079<br>1,200<br>692<br>249<br>94<br>220 | 1,620<br>250<br>569<br>66<br>50<br>106 | 1,284<br>104<br>155<br>32<br>32               | 21 6 - | 165 | 892<br>84<br>155<br>32<br>32<br>4 | 206 20 -                 | 97<br>13<br>18<br>10<br>6<br>4 |

<sup>\*</sup> Exclusive of four smaller hospitals. All federal hospitals in this area are operated by the Department of the Navy.

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Approximately 12 percent of the patients in the six hospitals listed in Table XIV are veterans, about 14 percent dependents and other supernumeraries, and 74 percent active-duty Navy and Marine Corps personnel. Thus the San Diego Naval Hospital alone could meet the needs of a military population more than two-thirds again as large as the present one. Perhaps 35 or 40 physicians are used to care for civilian patients and dispersion of facilities adds an unnecessary number for the care of military patients. The extent to which this dispersion is being carried is shown by the maintenance of a completely separate and independent 48 bed hospital for dependents alone, although a large dependent service easily capable of accommodating these patients is also being maintained at the San Diego General Hospital only a few minutes drive away.

Although the San Diego Naval Hospital has only 21 veteran patients hospitalized for service-connected conditions, the Veterans Administration plans the construction of a new 200 bed general hospital there in the near future. Furthermore with three naval hospitals of permanent construction and in good condition having a total capacity of over 1,000 beds (and with a patient load of only 228 that could be easily absorbed by the San Diego Hospital) there is certainly no good justification for the construction of another 200—bed hospital in this area.

The San Diego situation is remarkable in that a single federal agency controls the administrative means of effecting a sound plan for management of scarce medical facilities, yet has failed to do so.

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HOSPITALS OF THE FEDERAL GOVERNMENT IN SAN DIEGO AREA September 30, 1948

Table XV

|  |                | ospitals         |                    | al Dispens     |                           |                         |
|--|----------------|------------------|--------------------|----------------|---------------------------|-------------------------|
| Item                                   | Ocean-<br>side | San<br>Diego     | Training<br>Center | Air<br>Station | Marine<br>Recruit<br>Base | Amphi-<br>bious<br>Base |
|  |                |                  |                    |                | ,                         |                         |
| BEDS Total Capacity Operating          | 1,200<br>250   | 2,079ª/<br>1,620 | 692<br>569         | 249<br>66      | 94<br>50                  | 220<br>106              |
| PATIENTS IN HOS-<br>PITAL              | 104            | 1,284            | 155                | 32             | 32                        | 4                       |
| PERCENT OCCUPANCY<br>OF TOTAL CAPACITY | 9              | 62               | 22                 | 13             | 34                        | 2                       |
| OUTPATIENT CLINIC                      | yes            | yes              | yes                | yes            | yes                       | yes                     |
| PERSONNEL                              |                | 7 004            | w/ d               | 840            | 200                       | 2.5                     |
| Total Personnel Total Full-Time        | 242            | 1,278            | 568                | 72             | 220                       | 15                      |
| Doctors Residents and                  | 13             | . 97             | 18                 | 100/           | 6                         | 4                       |
| Interns                                | -              | 53               | -                  | -=-/           | <del>-</del>              | . ***                   |
| Staff Doctors                          | 13             | 44               | 18                 | 100/           | 6                         | 4                       |
| Part-Time Doctors Qualified Full-      | -              | 37               | -                  | 2              |                           | ₩.                      |
| Time Doctors                           | yes            | yes              | yes                | yes            | no                        | no                      |
| MEDICAL SCHOOL<br>AFFILIATION          | none           | none             | none               | none           | none                      | none                    |
| TYPE OF CONSTRUCTION                   | tempo-<br>rary | <u>a</u> /       | perma-<br>nent     | perma-<br>nent | perma-<br>nent            | tempo-<br>rary          |

a/ Capacity includes 1,348 permanent and 731 temporary beds.

<sup>/</sup> Capacity includes a hospital for active duty patients and a separate dependents hospital.

c/ An additional five fleet air officers are assigned temporarily.

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#### CONCLUSIONS

The five surveys reveal essentially the same pattern of waste and duplication of physical facilities and scarce medical personnel, inadequate quality of medical care for armed forces personnel at smaller installations, unwarranted construction of new facilities, and lack of clear policy with regard to contingent beneficiaries — all resulting from the lack of a central plan for federal medical care.

#### Personnel

The surveys document the charge of wasteful and inefficient use of scarce medical personnel by the federal medical services, especially the armed forces. Too many small hospitals are kept open when economy and efficiency in utilization of personnel require concentration of patients in larger centers. Taken together the military hospitals with a constructed capacity of 21,555 beds and an operating capacity of 12,851 beds, contain about 7,800 patients, giving occupancy rates of about 36 and 60 percent respectively. A large part of the medical resources of the armed forces is devoted to the care of civilians, some veterans, other dependents of military personnel on active duty, and a few miscellaneous others.

In the five surveyed areas military hospitals contained about 7,800 patients of whom only 61 percent were active duty military personnel. Another four percent were veterans with service-connected disabilities while 17 percent were dependents and others (non-veterans) and 18 percent were veterans with nonservice-connected disabilities. Thus 35 percent of the inpatients receiving care in the surveyed military hospitals were, at best, contingent federal

#### 144 July 184

beneficiaries. Care of such patients is not part of the primary medical mission of the armed forces in areas where civilian facilities are adequate. Most of the veterans in military hospitals do not have service-connected reasons for hospitalization. Military hospitals continue to care for appreciable numbers of chronic patients who should be discharged to the Veterans Administration more promptly. Many military hospitals appear to be definitely overstaffed in relation to their current patient census. This is also true of a few Veterans Administration hospitals. The staffing requirements of the armed forces are suspect, and in need of careful restudy predicated upon efficient utilization of personnel.

#### Physical Facilities

Too many hospitals are kept open by the armed forces, at great waste of operating costs, and at times with complete disregard for unmet civilian needs in the same community. In Los Angeles, San Francisco, Oakland, and San Diego counties Hill-Burton Act surveys reveal a need for an additional 10,000 beds for civilian use. New, permanent hospitals have been built by the military for the care of dependents. New construction is planned by the major agencies for their own individual needs without coordination of mutual needs and resources. In consequence, one agency will build a new hospital near an empty or nearly empty hospital of another. The Veterans Administration is embarking upon a huge building program the obvious purpose of which is to provide hospitalization for all veterans who need it, whether for service- connected reasons or not. This expansion does not take sufficient account

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of the possibilities of staffing the new hospitals with adequately qualified medical personnel. In fact, federal medicine at present is moving in a direction which will aggravate rather than solve its basic problems, lack of medical personnel. There is no consideration, in planning federal hospitals, for the possibility that they may later revert to another federal agency or to a nonfederal agency. At the present time, on the basis of existing policies and, even allowing for increases in the requirements of the various agencies, in the areas surveyed there is excess capital expansion projected or under contract the present estimated cost of which is in the neighborhood of \$100,000,000.

#### Medical Care

Repeated instances are seen in which contingent beneficiaries of the Veterans Administration are hospitalized in a large, well-staffed general hospital belonging to one of the armed forces, while many patients in the area are cared for in small, poorly-staffed station hospitals. This phenomenon occurs even when such hospitals have ample room for both the military and the veteran patients. In contrast to the Veterans Administration hospitals, which almost uniformly are affiliated with medical schools if such are nearby, the military hospitals make comparatively little use of civilian medical resources in urban communities, except for teaching purposes.

#### The Contingent Beneficiary

Although the veteran with a nonservice-connected reason for hospitalization has no more than a contingent right to hospitalization

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en en la companya de La esta de la companya under the law, the Veterans Administration hospitals, particularly the general hospitals, are caring primarily for nonservice-connected conditions. Percentages of 75, 85, and 90 percent occur in the hospitals surveyed. This is true not only of patients in hospitals in the Veterans Administration system but also of patients placed in other federal hospitals.

#### Organization

The federal government lacks any means of coordinating the major federal medical services at the present time, although such coordination is essential to the preservation of high standards of quality in medical care as well as to economy and efficiency in the utilization of medical resources. In the present highly competitive environment in which the individual agencies operate, the really strong pressures run counter to coordination, integration, and pooling of resources for efficient use. This is primarily because of personnel shortages. Each agency, in order to assure itself the medical resources for its primary mission, is forced to husband hospitals, personnel, and patients as the stuff of which a strong medical service is built. It must emulate civilian hospital practice, somehow obtaining a diversity of patients which the military population does not afford, and training its medical officers in such specialties as obstetrics and pediatrics. It must have acute and chronic patients, and must engage in the newer fields of medicine which are popular with younger physicians of good training, e.g. neoplastic disease. It must retain fixed installations if there is the likelihood of their being needed later, even though

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#### Summary

It is because of such considerations as these that the evidence of the surveys is damning, not to the individual agencies, but to the present federal organization for the provision of medical care. Too many hospitals are kept open by the armed forces, at great waste of operating costs, and at times with complete disregard for unmet civilian needs in the same community. New construction is planned by the major agencies for their own individual needs without coordination of mutual needs and resources. The Veterans Administration has embarked upon a huge building program most of which is to provide hospitalization for veterans who do not have service-connected conditions. Such expansion constitute a threat to the quality of federal medical care, and promises to aggravate rather than to solve the basic problem of lack of medical personnel. Finally, the federal government lacks any means of coordinating the medical programs of the separate agencies. So competitive is the environment in which they operate at present that no one agency can now take a government-wide point of view and hope to retain the resources for first-quality medical care. As long as this system continues, uneconomical and inefficient use of medical manpower and facilities will continue.

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COMMISSION ON ORGANIZATION OF THE EXECUTIVE BRANCH OF THE GOVERNMENT

#### APPENDIX D

REPORT OF THE
SUBCOMMITTEE ON TUBERCULOSIS
TO
COMMITTEE ON FEDERAL MEDICAL SERVICES



COMMISSION ON ORGANIZATION OF THE EXECUTIVE BRANCH OF THE GOVERNMENT

#### APPENDIX D

REPORT OF THE
SUBCOMMITTEE ON TUBERCULOSIS
TO
COMMITTEE ON FEDERAL MEDICAL SERVICES

Robert E. Plunkett, M.D. Richard Nauen M.D. Esmond Long, M.D., Advisor eg e grand had e e e e e. Grand e e e e e

The University of Pennsylvania

THE HENRY PHIPPS INSTITUTE

for the

Study, Treatment and Prevention of Tuberculosis

Seventh and Lombard Streets

Philadelphia 47

October 13, 1948

Mr. Tracy S. Voorhees, Chairman Medical Services Committee Commission on Organization of the Executive Branch of the Government Washington 25, D.C.

Dear Mr. Voorhees:

This letter summarizes my understanding of the report submitted by Dr. Robert E. Plunkett with regard to hospitalization of Federal Government beneficiaries.

In brief, Dr. Plunkett recommends, first, immediate consolidation of existing Federal tuberculosis hospital services in a single agency, for the sake of efficiency and solution of present personnel problems, and, secondly, formulation of a long range plan for gradual transfer of the program of tuberculosis hospitalization of Federal beneficiaries to the states and localities (state and county sanatoria) of the beneficiaries residence. Inherent in the first suggestion is the proposal that coincident with the consolidation of Federal services for tuberculosis there be a decentralization of authority on an appropriate regional basis, which would maintain ultimate responsibility in the Federal Government in Washington, but would place responsibility for details, including coordination with surrounding institutions, on a regional director who could handle local problems effectively.

After careful study of his report I am inclined to agree with both proposals. For immediate purposes it seems to me that these recommendations should be included in concise form in the final report from your office. Quite properly first emphasis should be placed on the suggestion of integration of Federal agencies as a matter of immediate urgency. There seems to be complete agreement in your committee on this objective.

It would be only proper, however, to lay stress, from the point of view of long range planning, on the other proposal, since there are many advantages in it, as pointed out in the details of Dr. Plunkett's report.

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As I indicated at the meeting, fundamental questions with respect to government are involved. We are in a period when there are vigorous advocates for: (1) complete Federalization of such services, (2) restoration of Federal services to private hospitals on a contract basis, and (3) the present proposal, which would preserve a type of governmental responsibility, but on the basis of states rather than Federal government. In the last analysis all would involve expenditure of federal funds, either directly or by reimbursement.

My own feeling is that this larger question will not be neglected by your committee, and that some uniform point of view must be preserved in the final report. As I say, after careful study, I have come to agree with Dr. Plunkett that in the long run the job can best be done on a state basis. Needless to say, a considerable amount of Federal assistance would be required to bring all state tuberculosis hospitals up to the level now maintained by the New York State hospitals.

Yours sincerely

//s/ ESMOND R. LONG

/t/ Esmond R. Long, M.D. Director

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#### COMMISSION ON ORGANIZATION OF THE EXECUTIVE

#### BRANCH OF THE GOVERNMENT

Report of the Subcommittee on Tuberculosis of the Medical Services Committee

#### INTRODUCTION

Tuberculosis differs in many respects from other diseases for which the federal government has assumed responsibilities. It is a communicable disease, as well as being costly and chronic. It is a serious public health, social and economic problem as well as a serious medical problem. It has profound and far-reaching effects on the welfare and economy of the nation.

Its toll is manifested in many ways. It causes about 50,000 deaths a year in the United States and is seventh among the major causes of death.

Experience shows that for every death from tuberculosis, there are at least 10 living active cases, so that in the country as a whole there are probably at least 500,000 persons with tuberculosis who need some type of medical supervision; some of them are known, but a large number of them are as yet undiscovered.

Tuberculosis is eminently a chronic, relapsing disease; it produces disability which may and frequently does extend over many years; it is often present in an active stage without producing

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symptoms or abnormal physical signs; treatment is prolonged; recovery is slow; and since one case comes from another, the disease is essentially a slowly spreading family epidemic.

Most of the cases occur during the most productive periods of life. To many of its victims the disease is a source of prolonged physical illness and disability. It results in loss of earning power of the individual and thus in disruption of the financial plans of his family. It strikes wage earners in the most productive age period of life; it is especially prevalent among women during the childbearing ages.

The tangible costs of the disease to the average community are measured in terms of hundreds of thousands of dollars and to the country as a whole in hundreds of millions. These include the initial investment in and the annual operating costs of tuberculosis hospitals; the costs of administration of control programs and of clinic, public health nursing and laboratory services; the expenditures of welfare agencies in behalf of the families of the tuberculous; and the prolonged expenses of medical care of chronic disease. In addition, there is the cost to society of broken homes, orphaned children, loss of earning power and productive capacity, and all other similar intangible social factors.

From all aspects, therefore, tuberculosis is a matter of foremost concern to the individual, the family and the community. Because
it affects the health and welfare of the whole community, the organized attack against the disease since its inauguration nearly sixty

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years ago, has more and more come to be recognized and accepted as a public responsibility. Successful prevention, treatment and control require a unified and well-organized <u>public</u> program in which all available services and resources must be utilized.

#### Extent and characteristics of the disease

The provisional death rate from tuberculosis, all forms, in the United States in 1947, was 33.2 per 100,000 population; the number of deaths for 1947, according to the provisional figures, was 47,636. This was the first time in the country's history that the number of deaths from this disease was below 50,000. Although the death rate has decreased 78 per cent since 1910, the problem is still a serious one.

The disease affects all age, sex, racial and economic groups of the population. However, it shows wide variations among the different components of the population. Tuberculosis is now primarily a disease of adults. Nearly one-half of all tuberculosis deaths occur among males between the ages of 20 and 65. The death rate for males is about 72 per cent higher than that for females. Rates among the non-white population are about three times as high as those for the white population. The rates among the states vary from 10 per 100,000 population to about 120. The rates are generally higher in the southwestern and the southern states.

A conspicuous factor which is associated with the prevalence of tuberculosis is that of economic status; this is a composite of

 many individual yet inseparable factors such as income, housing, nutrition, occupation, education, nativity and heredity.

#### Principles of tuberculosis control

The measures which are essential to control tuberculosis are:

- 1. To find all of the existing cases of tuberculosis.
- 2. To segregate those cases who are capable of spreading the disease to others.
- 3. To treat patients in order to render their disease inactive and noninfectious.
- 4. To rehabilitate patients physically, vocationally and economically.

These functions of case finding, isolation, treatment and rehabilitation are carried out through private physicians, chest clinic services, mass chest X-ray examinations, hospital care and treatment, public health nursing services, rehabilitation, medical social service and health education.

In the conduct of the various activities in tuberculosis control in the various subdivisions of the country and among the various components of the population, many different types of agencies are concerned in one way or another; these include the federal government, with its various facilities and services, state and local health departments, state, city and private tuberculosis hospitals, private physicians, general hospitals, laboratories, public health nursing services, voluntary health organizations, welfare agencies and others.

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The coordination of the work of these various agencies is essential. Because tuberculosis is not only a medical problem but also a public health, social and economic problem which affects the entire community, the various essential techniques for its effective control can not be separated from each other and conducted independently. This is reflected particularly in the inseparability of the medical care aspects of control from the other activities. However essential may be the clinical care of patients in hospitals, it is only one of the important procedures in the total scheme which spans from the first discovery and diagnosis of the patient through to his ultimate physical and economic recovery.

The time that the natient spends in the hospital is often only a relatively small portion of the total period during which medical and public health supervision must be provided. Therefore, the tuberculosis hospital can not be operated with maximum effectiveness unless its functions are properly and thoroughly integrated with all of the other essential community resources and services for tuberculosis control.

Moreover, efforts to control the disease in any one segment of the population can not be separated from the similar efforts which are necessary to control it in all other segments of the population. The community consists of persons who are individually basic components of such community, even though for one reason or another they may be classified as veteran or non-veteran, employed or unemployed, white or negro, male or female, child or adult, etc. In other words,

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the tuberculous veteran, soldier, sailor, merchant seaman or Indian, is as much a part of the community as is any other person with tuberculosis. This must be taken into account in planning the program of treatment and management of tuberculosis among federal beneficiaries.

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#### TUBERCULOSIS ACTIVITIES OF FEDERAL AGENCIES

The federal agencies conducting some type of program of tuberculosis hospitalization and medical care are the following: (1, 2)

Veterans Administration

Army -- National Military Establishment

Navy - National Military Establishment

Public Health Service -- Federal Security Agency

Bureau of Indian Affairs -- Department of the Interior

Bureau of Prisons -- Department of Justice

In addition to the direct medical care programs of the above agencies, the federal government assists in the tuberculosis control programs of the states by grants-in-aid (1) for general tuberculosis control activities through the Tuberculosis Control Division of the Bureau of State Services of the Public Health Service, and (2) for construction of hospitals, including tuberculosis hospitals, through the Hospital Facilities Division of the Bureau of State Services of the Public Health Service.

# Historical development

The federal agencies mentioned entered the field of tuberculosis hospital and medical care progressively as a part or branch of the general medical care programs for their beneficiaries and not primarily for the purpose of establishing a general tuberculosis control program for those beneficiaries.

The history of the tuberculosis hospital function of the Veterans Administration is of special interest. (3) Hospitalization

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of veterans was first authorized by law in 1917. In 1922, tuberculosis was first mentioned specifically in legislation, and hospitalization for nonservice connected disabilities was first authorized by law.

In 1933, existing laws governing hospital treatment were repealed, basic conditions of entitlement were prescribed and broad authority was given to the President to prescribe by regulation prerequisites for entitlement. Subsequent regulations authorized the hospitalization of all veterans with tuberculosis, whether service connected or nonservice connected, if they were incapacitated and had no adequate means of support.

In 1934, the law of 1933 was amended to authorize <u>hospitali-</u>
<u>zation for veterans of any war with nonservice connected disability,</u>
<u>disease or defect when in need of such hospitalization and unable</u>
<u>to pay the expenses therefor</u>. In 1943, an amendment placed World
War II veterans on a parity with World War I veterans.

The net effect of the present provisions is that hospital care by the Veterans Administration is available for all veterans with tuberculosis, since very few tuberculous patients in any group are able to pay for their own treatment.

### Extent of responsibilities for tuberculosis care

# Veterans Administration

The present scope of the responsibility of the Veterans Administration for the provision of tuberculosis care is as follows: (4)

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- 1. Hospital care for service connected cases in federal or other hospitals.
- 2. Hospital care for nonservice connected cases when a bed in a Veterans Administration hospital is available.
- 3. Outpatient care and private physician care for service connected cases.

In addition, the Veterans Administration contemplates a tuberculosis control program among all veterans. (5) Activities in this connection include:

- 1. Installation of tuberculosis case registers in the central office and in the branch and regional offices.
- 2. Promotion of routine chest X-raying among: (a) employees of the Veterans Administration, (b) Veterans Administration patients treated in other than tuberculosis hospitals, and (c) all veterans visiting Veterans Administration facilities for pension examination.

#### Army

The Army provides full care and hospitalization for military personnel until "maximum hospital benefit" has been achieved. (6)

This term is interpreted by the Army authorities as the phase at which there is no further need for active treatment, such as the initiation of some type of collapse therapy, antibiotic therapy, and the like. Thus, when the patient needs only further domiciliary type of care, the Army policy is to discharge him to a veterans hospital. There is no specified arbitrary time limit for such treatment.

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The Army provides hospitalization for dependents of Army personnel, but only as its facilities are available and only until facilities elsewhere become available. Priority for such care is based upon the relative medical and economic urgency of the given case. There is no provision for care of dependents in hospitals other than those operated by the Army.

Tuberculosis hospital care by the Army is also available for:

(1) its overseas civilian employees returned to this country when facilities are not available near their homes, (2) compensable tuberculosis cases among federal employees, and (3) tuberculosis cases from the Old Soldiers' Home at Washington.

#### Navy

The Navy provides tuberculosis care for naval personnel for at least six months and until the patient can be transferred elsewhere for satisfactory care, except that the patient himself may request transfer sooner. (7) Patients are usually transferred upon discharge, but in some instances they are technically discharged and retained in naval hospitals as patients of the Veterans Administration or as so-called "supernumerary" patients.

The Navy does not provide care for dependents of personnel or for civilian employees, other than compensation cases.

The Navy conducts a tuberculosis case finding program among service personnel. A similar program is also in effect for its civilian employees which includes X-ray examination before employment,

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### Public Health Service

The Hospital Division of the Bureau of Medical Services of the Public Health Service is responsible for care of tuberculosis among its commissioned officers and their dependents, officers and enlisted men of the Coast Guard and members of the Merchant Marine. (1,8) For most of these beneficiaries it provides complete impatient and outpatient care and the services of special consultants as needed. For compensation cases, the Service provides only the hospital care, and the Bureau of Employees Compensation must pay any additional expense incurred. Veterans are also taken by the Service at the request of the Veterans Administration, but are given hospital care only. Dependents of Coast Guard officers and enlisted men receive outpetient care, and when facilities are available, impatient care also. Consultant services are not provided for such dependents.

In addition, the Public Health Service has photofluorographic X-ray equipment in 14 of its hospitals and in four clinics; all impatients and, so far as possible, outpatients receive chest X-ray examinations; no other special tuberculosis case finding program is conducted among Public Health Service beneficiaries.

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#### Bureau of Indian Affairs

The Bureau of Indian Affairs provides hospital and medical care for tuberculosis cases among its beneficiaries and conducts some case finding through the use of two mobile photofluorographic X-ray units.

#### Bureau of Prisons

The Bureau of Prisons operates a general hospital with a tuberculosis department at Springfield, Illinois, to which all tuberculosis cases among Federal prisoners are transferred for care. The
Bureau has a program of chest X-ray examination of federal prisoners
(10)
upon entry into prison.

#### Conclusions

The fact that the responsibility of the Federal agencies for tuberculosis hospital and medical care for their beneficiaries originated and developed only as a part of the much larger general medical care programs of these agencies has led to two major consequences which have an important bearing upon the adequacy of the present federal tuberculosis services.

One result has been that each of the tuberculosis programs described is almost exclusively a medical care or treatment program, with insufficient emphasis upon the total, long-range tuberculosis control scheme which spans from the first discovery of a case through the significance of the case to the family and county. In other words, the tendency is for primary emphasis to be placed largely

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upon the clinical care of patients, without sufficient consideration of all of the other principles of tuberculosis control.

Simultaneously, a parallel second result has been that the tuberculosis program of each federal agency has evolved along its own lines, with little or no integration or coordination with the tuberculosis programs of the other federal agencies or with the general tuberculosis control programs of state and local agencies.

#### Extent of the problem of federal tuberculosis care

The quantitative extent of the responsibility of federal agencies for tuberculosis hospital and medical care may be expressed in terms of the estimated populations involved, the number of hospitals concerned and the present capacity of those hospitals.

#### Populations

The approximate total populations with which the federal agencies are concerned are as follows: (1)

Veterans - 18,000,000
Armed Forces - 1,500,000
Merchant Marine - 100,000
Coast Guard - 20,000
Indians - 420,000
Prisoners - 17,500
TOTAL - 20,057,500

#### Hospitals

# Veterans Administration (11)

The Veterans Administration operates 18 tuberculosis hospitals with a total capacity of 9,000 beds; about 7540 of these beds are evailable at any one time for tuberculosis patients.

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In January, 1948 there were about 13,500 tuberculosis patients in Veterans Administration hospitals, of whom about one-half were nonservice connected cases. In 1947, about 16,400 tuberculosis cases were discharged.

# Army (6)

The Army operates one tuberculosis center as a unit of the Fitzsimons General Hospital at Denver, Colorado. The total capacity of
the hospital of over 2,000 beds includes a flexible capacity for tuberculosis patients. In 1948, about 850 beds were occupied by tuberculosis patients; of these 850 patients, about 600 were Army patients
and about 250 were Veterans Administration patients. About 1,500
tuberculosis cases are discharged annually.

# Navy(7)

The Navy operates tuberculosis units in two general hospitals

-- St. Albans, New York and Corona, California. The capacity of
each of these tuberculosis units is 250-300 beds. The average census
at St. Albans is 255 and at Corona 183, for a total of 438.

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# Public Health Service (8)

The Hospital Division of the Bureau of Medical Services of the Public Health Service operates two special tuberculosis hospitals, one at Neponsit Beach, New York, with about 260 patients, and the other at Fort Stanton, New Mexico, with about 175 patients. Also, there are about 100 patients in a tuberculosis unit of a Public Health Service general hospital at San Francisco, California. In addition to these 500 tuberculosis patients, about 300 others with tuberculosis are in various Public Health Service general hospitals.

Through its Hospital Division, the Public Health Service operstes the Freedmen's Hospital at Washington, D. C., which has a
tuberculosis unit of 142 beds. This hospital is essentially a
teaching and training hospital for negro physicians and nurses. The
cost of care of patients admitted must be paid either by the patients
or by the locality in which the patients reside; most of the patients
are residents of the District of Columbia.

# Bureau of Indian Affairs (12)

The Bureau of Indian Affairs operates nine tuberculosis hospitals in the United States and one in Alaska, with a total capacity of about 1,000 beds.

# Bureau of Prisons (10)

About 60 tuberculosis cases are hospitalized at the 1,142-bed general hospital operated by the Bureau at Springfield, Illinois to which all tuberculosis cases among federal prisoners are transferred for care.

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#### Summery

The federal agencies which conduct tuberculosis hospital and medical care programs are concerned with a total population of over 20 million persons, or about one-seventh of the nation's population.

The number of hospitals involved includes about 30 special tuberculosis hospitals and over 50 general hospitals with tuberculosis units. The number of patients hospitalized at any one time in these hospitals is about 16,000, exclusive of tuberculosis patients in various miscellaneous type of hospitals.

#### Cost

The cost of the federal tuberculosis program can not be determined accurately from data presently available. About 940 million dollars a year is spent for the total federal program of hospital and related activities. (1)

An estimate of the partial cost of tuberculosis hospitalization can be derived as follows: The daily cost per patient of operating the Veterans Administration tuberculosis hospitals is \$11.29, and that of the Public Health Service tuberculosis hospitals \$8.33. (13)

Assuming on this basis an average daily cost of \$10.00 for the approximate 16.000 patients in the Veterans Administration, Army, Navy,

Public Health Service and Indian Affairs hospitals, the annual cost is about 60 million dollars. This excludes the costs of contract service of the Veterans Administration, private physician care, outpatient services in hospitals, branch and regional offices, administrative costs, etc.

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The above partial cost figure of 60 million dollars annually may be contrasted with the estimated 7 million dollars to be spent by the Public Health Service through grants-in-aid to states for tuberculosis control programs (1) and the estimated seven to ten million dollars which will be available to states in 1949 for tuberculosis hospital construction through the Hospital Facilities Division of the Public Health Service. (8, 14)

## Estimated future federal tuberculosis hospital needs

From date presently available it is not possible to estimate reliably the extent of the tuberculosis hospital facilities which may be needed in the future for the care of the various federal beneficiaries with tuberculosis. However, some idea of such future needs may be obtained from the following observations.

A long-term estimate by the Veterans Administration of tuberculosis hospital case loads indicates a gradual rise from an actual
total in 1947 of 12,436 patients to a maximum by 1951 of 15,045
patients. (15) However, this estimate is not based upon a separate
consideration of service connected and of nonservice connected
cases, nor upon other factors, especially the decline in tuberculosis in the general population since World War I, and the more
effective pre-induction screening out of tuberculosis cases in
World War II.

Although 50 per cent of all veterans hospitalized for tuber-culosis in January 1948 were nonservice connected, this proportion was 84 per cent for World War I veterans but only 35 per cent for World War II veterans.

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It is probable that the number and proportion of service connected tuberculosis cases will be much larger in the future than it was after World War I because of the large number of persons in the Armed Forces and the resumption of the selective service program.

Nonservice connected cases among peace-time veterans are not eligible for Veterans Administration care. (16)

Information is not yet available regarding the expected incidence of tuberculosis among Army personnel. The rate in the Navy
is about 60 new cases per 100,000 persons per year. (7) If the same
rate prevails in the Army, which has a similar type of population,
there would be about 600 new cases annually in an Army of one million
and about 300 new cases in a Navy of about 500,000.

As for Public Health Service beneficiaries, it can only be estimated that at least the present case load of about 800 hospitalized tuberculosis cases will continue, but if a comprehensive case finding program among Merchant Seamen is instituted, that number would in all likelihood become much larger.

The number of tuberculosis cases among Indians is unknown. If an energetic case finding program were instituted, the tuberculosis hospital case load would undoubtedly increase above the present one and more beds than the present 1,000 beds would be needed.

Assuming a prevalence of two tuberculosis cases requiring hospitalization per 1,000 prisoners, there would be about 35 such cases among the 17,500 present federal prisoners. Since there are now about 60 prisoners receiving tuberculosis hospital care, the present load is as high as might be expected with the present prison population.

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#### PRESENT ORGANIZATION OF FEDERAL AGENCIES

#### Veterans Administration

The Administrator of Veterans Affairs is responsible to the President for the conduct of the Veterans Administration; next in line of authority is an Executive Assistant Administrator. (17)

Neither of these positions has been filled by a physician.

Within the central office, there are 12 main subdivisions, each headed by an Assistant Administrator. (18) One of these 12 is the Chief Medical Director, Department of Medicine and Surgery.

The tuberculosis hospital and medical care program of the Veterans Administration is an activity of this Department, which was created by an act of the 79th Congress. This act states that "The functions of the Department of Medicine and Surgery shall be those necessary for a complete medical and hospital service, to be prescribed by the Administrator of Veterans Affairs."

The Chief Medical Director is thus the only one of the 12
Assistant Administrators who has a specific legal status. However,
on the same level of authority are Assistant Administrators for such
services as Personnel, Contact and Administrative Service, Construction, Rehabilitation, and the like. Therefore, despite the
clear intent of Congress to establish through the Department of
Medicine and Surgery a complete hospital and medical service, the
Chief Medical Director does not have complete authority over this
service.

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Within the Department of Medicine and Surgery is a Professional Service of several Divisions, among them the Division of Tuberculosis, headed by a Chief who is responsible to the Chief Medical Director.

Below the central office level the Veterans Administration is subdivided into 13 Branch Offices, whose organization is virtually a replica of that of the central office. Each is headed by a Deputy Administrator, below whom there is an Assistant Deputy Administrator; usually both are non-medical persons.

Within the Branch Office there are ten positions, of which one is Branch Medical Director, in charge of the Medical Service. Within each Medical Service there is a Tuberculosis Section under a Chief.

Under each Branch Office are the Veterans Administration tuberculosis hospitals. Primary authority for the operation of the hospitals is vested in a Manager who is responsible to the Deputy

Administrator. Under the Manager is an Executive Officer. The
Manager may be a physician, but the Executive Officer usually is
not. Below the Executive Officer is a Chief of Professional Services
and chiefs of the various divisions for Finance, Personnel, etc.

Thus, in relation to the Manager the Chief of Professional Services
is on the same level as the chiefs of the ancillary services.

In effect, then throughout the entire Veterans Administration organization, medical personnel are subordinated to non-medical personnel in the conduct of the medical care program. At the central office level, the Chief Medical Director and his Division Chiefs have authority only over the medical program itself and then only through the Deputy Administrator in the respective Branch Office,

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who is usually not a physician. The Chief Medical Director and the Chiefs of Divisions are responsible only for professional and technical care of patients, and they give only technical supervision, guidance and assistance to the Branch Medical Directors, Branch Section Chiefs, Tuberculosis, and the hospital Chiefs of Professional Services and Chiefs of Tuberculosis Service. All of this technical guidance and assistance must be filtered through the non-medical personnel, who are placed in the line of authority and are the official channels of communication.

It is to be doubted whether non-medical personnel can ever be fully indoctrinated with the essential principle that the fundamental purpose of the medical care program of the Veterans Administration or of any other agency is the diagnosis, treatment and prevention of disease, and that all related and required offices and services of the Veterans Administration or other agencies must assist the medical personnel in fulfilling this function.

While it is true that in some instances Managers have avoided some of the difficulties of this pattern by having the Chief of Professional Services report directly to the Manager, (19) this merely illustrates the need for a change in the pattern, so that it would not be necessary for Managers to circumvent the regulations in order to obtain a workable system of administration. However, even this does not overcome the injurious effect of a system which tends to bring about the elevation of various branches of the hospital service into separate semiautonomous units, competing with one another for

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the necessary personnel, funds, supplies and equipment, rather than all working as a team to assist the medical service in its medical care functions. Only by establishing medical administration as the supreme authority in the hospital and medical care program of the Veterans Administration, with the line of authority extending from central office to Branch Office, to hospital, to ward physician, through medical personnel, can a satisfactory solution of this problem be reached.

## Army (6)

In the organization of the Army tuberculosis hospital service, the line of authority extends from the Hospital Division of the Surgeon General's office directly to the Commanding Officer of the Fitzsimons Hospital, who is always a physician and who has under him an Executive Officer, also a physician. Below him are Chiefs of Medical Services and of Surgical Services. The Chief of Medical Services directs the activities of the ward officers, and, at Fitzsimons Hospital, is a tuberculosis specialist.

In general, the Army medical organizational plan seems well designed for the operation of the hospital services. One criticism is that, because tuberculosis is a relatively minor problem in the Army's medical service, it can not receive the special attention and special organizational structure which it requires.

# Navy(7)

In the Navy, the line of authority extends from the Surgeon General of the Navy directly to each Naval District Medical Officer

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General, who is then advised on specific problems by specialists on his own staff. In most instances, decisions on problems are made by the Chief of the respective specialty division. The Navy does have a Director of Tuberculosis Control in the the Bureau of Preventive Medicine who has the additional responsibility of conducting case finding programs for naval and civilian personnel. The Army does not have such a full-time position, but has a well qualified tuberculosis consultant to the Surgeon General.

The same criticism applies to the Navy's organizational pattern as to that of the Army, with the exception that the Navy does have a tuberculosis specialist in the service who can be called upon for advice and assistance. The organization is such that tuberculosis in the Navy is handled as a branch of Internal Medicine, rather than as a special problem requiring specialized organization.

The organization of the Army and Navy tuberculosis hospital services places final authority always in the hands of medical personnel. All other services are considered auxiliary to the medical service. As a result, this system appears to function very smoothly in obtaining for the Medical Departments the support required in cerrying out first quality medical care.

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# Public Health Service (8)

The tuberculosis hospital and medical care program of the Public Health Service is operated by the Hospital Division of the Bureau of Medical Services. The line of authority extends from the Chief of the Hospital Division to the Medical Officer in charge of the Hospital who may have a Deputy Medical Officer or Clinical Director under him and a number of Junior Medical Officers. Most of the general hospitals have residents or interns but apparently there are none in the present Public Health Service tuberculosis hospitals. In addition, there is usually a non-medical administrative officer to assist the medical officer in charge.

In all of the Public Health Service Marine hospitals the officer in charge is a physician. In the Freedmen's Hospital, (20) a hospital for negroes at Washington, D. C., which has recently been placed under the Public Health Service Hospital Division, the superintendent is a layman, who, however, has had experience in hospital administration. The members of the permanent medical staff at Freedmen's Hospital, on the other hand, are not employed by the Public Health Service but are employed by Howard University, a medical school for negroes, and assigned to serve in the hospital for the dual purpose of teaching medical students and nurses and of treating patients. Medical residents are employed by the hospital. All other personnel are under Civil Service and are also employed by the hospital.

In this organizational pattern, as in the Veterans Administration pattern, the deficiencies of lay management are again apparent.

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 These deficiencies are probably even greater because of the dual supply for hospital personnel. Moreover, the medical school naturally conceives the primary function of the physicians assigned to the Freedmen's Hospital to be that of teaching and can afford to assign only enough personnel for this purpose, so that the care of patients necessarily becomes a secondary function. In other words, more or less the same difficulties arise as in the Veterans Administration hospitals where the personnel in the non-medical services apparently do not realize that their primary function is to assist the medical services in the care of patients, but instead conceive of themselves as semiautonomous units competing for authority, prestige, supplies, and personnel and budgetary allowances.

# Bureau of Indian Affairs (21)

The Bureau of Indian Affairs operates its own health program through its Division of Health. The Director and five other supervisory personnel in this program are assigned to the service by the Public Health Service Division of Commissioned Officers and are paid by the Public Health Service which, however, is reimbursed by the Bureau of Indian Affairs. The remainder of the medical staff of the Indian health program are Civil Service employees employed by the Bureau itself. The Indian Affairs hospitals are directed by physicians.

The principal organizational defects in the Indian health program appear to result from the division of authority and responsibility

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between the Public Health Service and the Bureau of Indian Affairs, and from the inability of the Bureau to secure sufficient appropriations from Congress to carry out preventive as well as curative medical programs. Integration of the Indian health program with those of other Federal agencies would permit more efficient medical services and facilitate arrangements for providing medical care for Indians through state and local facilities.

## Bureau of Prisons (22)

The Bureau of Prisons operates a large general hospital at Springfield, Illinois, which is directed and staffed by physicians assigned by the Public Health Service. A tuberculosis department at this hospital is headed by a physician with special tuberculosis training. The organization of this hospital seems satisfactory from the standpoint of facilitating good medical care.

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#### ADMINISTRATION OF THE TUBERCULOSIS PROGRAMS OF FEDERAL AGENCIES

#### Long-range program

#### Principles involved

A program for the control of tuberculosis must take into consideration the fact that this is eminently a disease which affects not only the individual afflicted with it, but also his family and the community in which he lives. To confine control measures merely to the clinical treatment of the lesion in the individual patient, without due consideration for the broader, public health or community implications, is to strike merely tangential blows at the tuberculosis problem and to retard successful control of the disease on all its fronts.

Treatment of the patient. By the same token, one outstanding fact firmly established through the experience of the years during which tuberculosis has been treated in hospitals is that the treatment of the patient is best carried on in intimate relationship with the community of which the patient is a part.

This principle is not fulfilled by the policies and practices of the tuberculosis hospital programs of the Federal agencies.

In the first place, federal beneficiaries constitute only about one-seventh of the total population, so that theoretically each federal hospital serves a geographic area about seven times as large as would be served by a hospital serving the entire population of a community.

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This means that the federal hospitals are usually located at great distances from the patients' homes. This is important not so much because of the travel of the patient to and from the hospital, but vitally more so because the patient has to stay in the hospital for many months, and often for a period of years. In order that the patient may be persuaded to remain in the hospital for an adequate period of time, there must be provided suitable opportunities for the patient and his family to see each other reasonably frequently.

Because of the geographic characteristics of the present federal tuberculosis hospital system, such opportunities are for the most part lacking. To cite one extreme example of this factor, many tuberculosis patients who are Army beneficiaries must be transported from their stations or from their home communities to Fitzsimons Hospital at Denver, Colorado, past innumerable tuberculosis hospitals operated by other federal agencies. Similar illogical practices occur with respect to the beneficiaries of the Navy and of the Public Health Service.

At least in years past, this situation has been further aggravated by the tendency to locate some federal hospitals in remote, relatively isolated places, either because of the mistaken notion that tuberculosis must be treated in the mountains or in the woods, or possibly because of the influence of persons interested in securing such locations,

A problem often discussed in connection with Veterans Administration tuberculosis hospitals but which is common to all tuberculosis hospitals is that of patients leaving the hospital prematurely, that The first section of the section of

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Another immortant reason for the lack of a satisfactory relationship between the federal tuberculosis hospitals and the people of communities is that through legislation, regulation, policy and practice the federal beneficiaries with tuberculosis have been handled as veteran, soldier, sailor, seaman, etc., rather than as constituent residents of the community. The reasons and the necessity for the development of such arbitrary, special handling are obvious and understandable, of course. But the unfortunate consequence has been the fostering and growth of the idea that the mere fact of being a federal beneficiary somehow sets one apart from one's relatives, neighbors and friends in the home community. Years of experience have amply shown that such attitudes on the part of patients in hospitals have been in no small part responsible for many of the past unsatisfactory features of federal tuberculosis hospital administration.

The advantages of establishing a close and harmonious relationship between the tuberculosis hospital and the community, that is, the people served by the hospital, are many and varied. The patients and their families adjust better and more readily to the necessity of hospital care. The community better appreciates the hospital and its medical staff. The private physicians acquire a sense of being active participants in the public program for tuberculosis

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en de la comparta de la composición de La declaración de la composición de la control through their relationships with the hospital. The hospital staff in turn better understands the community from which the patients come, its problems and the social and emotional background of the patients. The staff develops a sense of responsibility to the community it serves.

A continuity of patient-physician relationship is developed. In the ideal scheme, the patient's disease is diagnosed by a physician from the hospital and the patient is admitted to the hospital where the same physician either cares for him or at least participates, through conferences and otherwise, in his medical care. If social difficulties exist, the local public health nurse or medical social worker brings them to the attention of the medical staff. When the patient returns home, a physician from the same hospital, who knows the patient and his medical history, further observes and guides him through the clinic service. Such a program contemplates a consultation service with the family physician.

The patient's family associates have in the meantime been examined by the hospital staff, and there has in many ways been engendered a realization that the hospital is a service provided by the community for its residents.

Few, if any, of these essential aids to more effective treatment and control of tuberculosis are available under the present
federal tuberculosis hospital system. To be sure, great advances
have been made in recent years in the quality of medical care provided, and advances have been made toward a more comprehensive,
more than clinical management of tuberculosis hospital patients,

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notably in the fields of rehabilitation and medical social work. But there exists, nevertheless, that basic lack of close relationship and sense of rapport between federal hospitals and the community.

This, then, is a most conspicuous and fundamental deficiency in the present federal programs of tuberculosis treatment.

Community control of tuberculosis. In considering the measures for combating tuberculosis in the community as a whole from the stand-point of accepted principles and practices, the conclusion is inescapable that the control of tuberculosis is in its most important aspects primarily and basically a responsibility of the individual states, which are the "communities" in which tuberculosis patients live, and in which the total control scheme must be carried on. The bulk of the federal beneficiaries, and particularly those of the Veterans Administration, belong in the category of "home community residents", who affect and are affected by tuberculosis in the general population of the community.

Under the existing system of federal tuberculosis hospital care most of the federal money spent for this has been spent with little degree of purposeful regard for the problems, programs and objectives of the various states, as communities, in their attempts to control the disease. There has been an almost complete lack of coordination of the tuberculosis hospital plans of the federal agencies with those of states. The same applies to an even greater degree to the actual administration of tuberculosis hospital programs.

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#### Conclusions and recommendations

Accordingly, with respect to improving the treatment of the individual patient by bringing tuberculosis services closer to the people they serve as well as improving the community control of the disease, the <u>long-range</u> plans of the federal government must provide for transferring gradually but progressively the direct responsibility for these activities to the states and localities.

Use of local facilities. The first major step toward this end should be the adoption of a policy of having federal tuberculosis beneficiaries treated in so far as possible in state and local tuberculosis hospitals and clinics. The formulation and execution of this long-range plan would be immensely simplified through the immediate consolidation of existing federal tuberculosis hospital services in a single agency. A single agency could obviously deal with the various states much more simply and expeditiously than the several independent and uncoordinated agencies could.

The policy of treating federal tuberculosis beneficiaries in state and local hospitals would be merely an expansion of a policy which has already been in effect for many years in the programs of the Veterans Administration, Indian Affairs and Public Health Service. It finds support in recommendations of the House Appropriations

Committee, in recommendations of various hospital and medical authorities, and in Canadian experience. However, in developing such a program, it would be essential to adopt the philosophy that federal beneficiaries be hospitalized under the same program

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of care and treatment as that provided for their fellow-residents from the same community, rather than as a different species of patients merely because they happen to be federal beneficiaries.

Federal aid to states. It is only too obvious that local tuberculosis facilities are inadequate in many areas. (23) Therefore, the next recommended step is that the federal government provide adequate financial grants to states for the construction of local facilities where the need for them exists, as determined jointly by federal, state and local agencies. In addition to providing the necessary facilities for federal beneficiaries, this program might well provide the stimulus and inducement for states to increase facilities to be financed entirely by themselves. In support of this proposal are recommendations by hospital authorities, (26) the existing program under the Hill-Burton Act, (27) and the experience of the Canadian government. (25)

In addition to grants for construction, and since the federal government has already assumed responsibility for certain beneficiaries, it is recommended that it also make available reimbursement to states for the operation of state and local facilities for the care and treatment of such beneficiaries. There is ample precedent for the soundness of such a program of reimbursement by a larger political unit to a smaller one for tuberculosis hospital care. Any such plan of federal reimbursement should, of course, be fortified with a requirement for conformance to minimal standards of hospital administration and medical care.

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The proposed plan of federal financial grants to states for tuberculosis hospital construction and of reimbursement for the operation of local facilities should be integrated with existing programs of federal grants for tuberculosis control purposes. These include the limited hospital construction funds under the Hill-Burton Act handled by the Hospital Facilities Division of the Public Health Service, and the funds for general tuberculosis control activities handled by the Tuberculosis Control Division of the Public Health Service.

Disposition of federal hospitals. The foregoing recommendations naturally raise questions about the federal government's own present and future hospital construction program. In keeping with the basic premises, it follows that no new federal tuberculosis hospitals should be built other than those already under construction, and these should be transferred to state operation as the recommended long-range program develops.

Certainly any plans for building any type of federal tuberculosis hospitals in remote and inaccessible locations should be abandoned promptly.

Some of the present Veterans Administration tuberculosis hospitals have been difficult to operate efficiently because of their size or location, because of inability to secure the necessary personnel, or for other reasons. As soon as other adequate facilities are available, such tuberculosis hospitals should be discontinued as such.

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The foregoing recommendations for transferring responsibility for tuberculosis hospital care to states represent a <u>long-range program</u>. It is recognized that it can not be effected even in the near future. In order that it may be carried out effectively, efficiently and without jeopardizing the interests of the beneficiaries concerned, it should therefore be put into effect <u>gradually</u>. It will require careful and thorough planning jointly with the states concerned.

Furthermore, there are and will undoubtedly continue to be some classes of federal tuberculosis beneficiaries who, for one reason or another, can not be cared for otherwise than directly in federal facilities. To meet their needs, an efficient and well-integrated federal program is obviously desirable.

#### Immediate program

#### Present practices

The operation of separate tuberculosis hospital programs by five federal agencies inevitably results in inconsistencies, duplications, deficiencies and inefficiencies. There is an imperative need for integration of these activities.

Classes of beneficiaries. (28) This need is manifest particularly in relation to the classes of beneficiaries for whom the agencies provide services. In the main, the responsibility of each of the agencies is limited to certain specified groups of beneficiaries. There are arrangements for exchange of tuberculosis hospital services whereby the Public Health Service, the Army and the Navy accept

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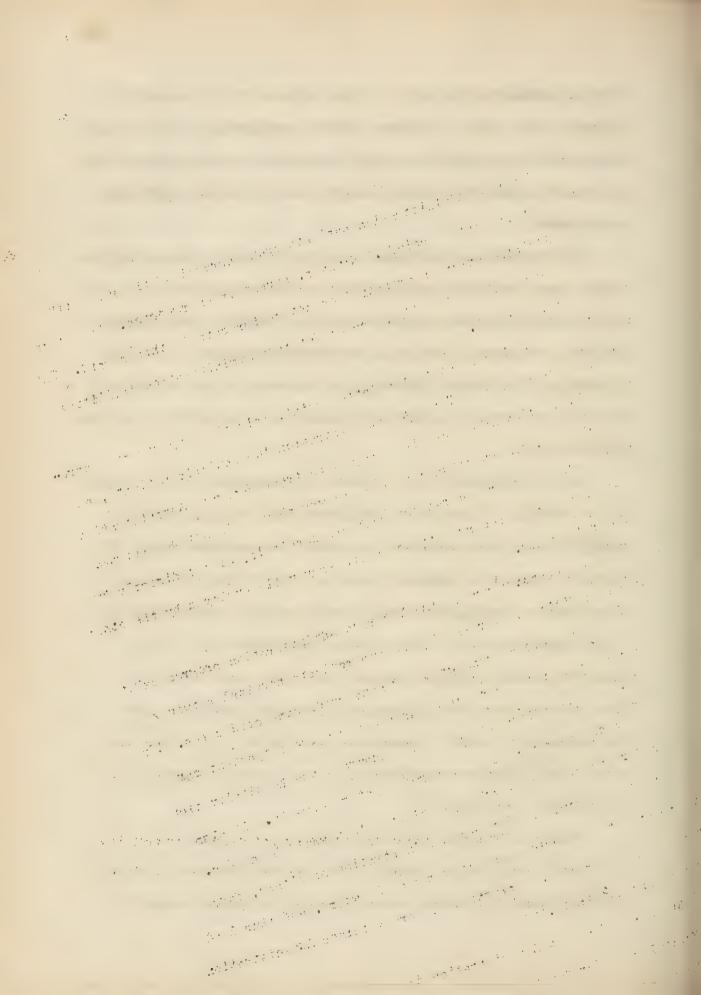
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With respect to the latter point, only the Army has any appreciable number of Veterans Administration tuberculosis patients, and if Army physicians can be assigned to treat Veterans Administration patients, the question arises as to why they could not be assigned to work in other federal tuberculosis hospitals, either directly by the Army or on reserve status in the Army while employed by the other federal agency.

An inconsistency in the Veterans Administration program exists in the definite difference in the tuberculosis hospital services available to service connected and nonservice connected cases. The fact that nonservice connected cases can receive outpatient care only after hospitalization tends to encourage the hospitalization of many such cases who might otherwise not receive it. It also makes for longer periods of hospital stay than would be needed. This tends to crowd the Veterans Administration hospitals, force the treatment of service connected cases elsewhere, and thus lead to the demand for the construction of more Veterans Administration tuberculosis hospitals. (29)

While the Veterans Administration does not provide tuberculosis hospital care for dependents of veterans or even for dependents of Veterans Administration personnel except in case of emergency,



the Army, and the Public Health Service do provide such care for dependents of their own personnel.

Thus, there does not seem to be enough flexibility for exchanges of beneficiaries, services and personnel among the principal federal agencies in tuberculosis hospital care, nor sufficient uniformity of policy and practice. The reason, of course, is that this responsibility originated and developed only as a part of the much larger general medical care programs of these agencies and therefore the tuberculosis program of each has evolved independently along its own lines.

Inter-agency coordination. The consequences of lack of integration are evident also in many other respects. (30) Estimation of the extent of the problems or case loads of the respective agencies has apparently been done more or less independently. The same seems to apply to the planning, location and construction of tuberculosis hospital facilities, and to joint planning and handling of important problems such as recruitment and training of personnel, medical, surgical and nursing care of patients, research, medical social work, rehabilitation, food service, etc.

Not only is there inadequate coordination among different federal agencies, but also even within the same agency. An example is the failure of the Hospital Division of the Bureau of Medical Services of the Public Health Service to establish a comorehensive tuberculosis case finding program among some 100,000 merchant seamen, despite the fact that the Tuberculosis Control Division of the Bureau

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of State Services of the Public Health Service is one of the strongest and foremost proponents of mass case finding in tuberculosis and despite the observed high prevalence of tuberculosis among the merchant seamen.

Coordination with states. Still another deficiency is the lack of satisfactory relationships between federal agencies and the various states. (30) In this, there has been a variable degree of coordination.

All of the principal agencies do carry out the essential activity of reporting tuberculosis cases to the local health authorities.

The Hospital Facilities Division of the Bureau of State Services of the Public Health Service has worked very closely and cooperatively with the states in planning for various types of hospital facilities in the country. However, the Veterans Administration particularly, and evidently also the Hospital Division of the Bureau of Medical Services of the Public Health Service and the Bureau of Indian Affairs have planned or located new tuberculosis hospitals largely independently of the Hospital Facilities Division of the Public Health Service as well as independently of the states concerned.

In other words, the Veterans Administration plans hospital facilities for its beneficiaries, the Bureau of Indian Affairs for its beneficiaries, some of whom may also be veterans, and the Army and Navy for their beneficiaries. Meanwhile, each state estimates its own tuberculosis hospital needs on the basis of its annual average tuberculosis deaths, disregarding the fact that some of the

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deaths were among veterans, Indians, or merchant seamen and that such deaths have already been used in estimating the hospital needs of the federal agencies. Indeed, states are required to exclude federal hospitals in estimating their total needs under the Hill-Burton Act.

Hospital administration. The medical care programs of the hospitals of some of the federal agencies are hampered by the subordination of the medical organization to non-medical authority. (30) This is notably so in the Veterans Administration hospitals and is also true at the Freedmen's Hospital. In other words, there is a lack of a medical autonomy in the individual hospitals which is essential for the conduct of a high quality medical program. There is thus a need for a strong medical organizational structure.

The administrative practices of the Veterans Administration hospitals and the Freedmen's Hospital aggravate rather than ameliorate the deficiencies in organization. The medical services which have been improved so markedly in the last few years are impeded by these practices in their efforts to give the best possible care to patients.

Particular difficulties result from current practices relating to budget preparation and allocation of funds to hospitals; these functions are exercised mainly by non-medical officials.

The failure to allocate annually a definite sum for the operation of each hospital and the procedure of quarterly allocation of funds result in inability to plan efficiently for the operation of the hospital. The state of the second section of the section of the second seco

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Although the function of the Special Services program is to help in the patients' recovery, it is not directly supervised by the medical staff.

Difficulties exist also in relation to such matters as supply, construction, repair, inspection service, and others-

Only the development of policies and practices based upon sound medical principles and their administration by a strong medical organization will make possible the correction of existing shortcomings.

Personnel. Throughout the federal tuberculosis care system, there is a considerable shortage of specially trained tuberculosis physicians. (30) One reason for this is that the existing recruitment programs are not completely effective, but the principal reason is that the medical career opportunities of the federal service do not appear particularly attractive to many young physicians. This in turn is due to the fact that medical care itself is not sufficiently recognized in the federal medical service as the primary purpose of these programs. The resulting non-medical administrative domination acts as a deterrent to recruitment of physicians.

From the special standpoint of tuberculosis, two important factors are that in some of the federal agencies, not enough physicians are assigned to tuberculosis services of hospitals to acquire the necessary specialized tuberculosis training and experience, and secondly, after they do acquire such training, many of them are transferred to other types of services,

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Too frequent transfers of location, the relatively isolated location of many of the tuberculosis hospitals, the resulting unattractive community life, the inadequate living accommodations in some hospitals, the fear of exposure to tuberculosis — these are other factors which adversely influence medical recruitment.

Moreover, there is in general insufficient opportunity and access to professional education, in-service training, and research for tuberculosis physicians.

For the medical personnel in Indian Affeirs and for non-medical personnel generally, the rigid restrictions of the Federal Civil Service add to the difficulties of operating the medical programs.

The shortage of trained tuberculosis physicians is further aggravated by the lack of coordination among the federal tuberculosis agencies and the resulting competition for and inefficient use of this class of personnel.

Because the Army, Navy and Public Health Service have relatively small numbers of tuberculosis hospital patients, they can not afford adequate numbers of qualified tuberculosis physicians. Also, the treatment of chronic disease in Army and Navy hospitals diverts already scarce medical manpower from necessary military duties. The service man with tuberculosis during the period of disability is unable to give even minimal service to his unit, but is instead a considerable liability. Yet the Army gave about 280,000 patient days of care for tuberculosis in 1947 and the Navy about 220,000 patients days; this represents about 1,500 and 1,000 tuberculosis patients, respectively.

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### Conclusions and recommendations

The inconsistencies and shortcomings of the federal tuberculosis hospital and medical care programs reflect the difficulties of operating five or more separate and uncoordinated programs. They reflect particularly the fact that each program was developed piecemeal as responsibilities were successively added to each agency for the care of persons who were veterans, soldiers, sailors, Indians and so forth. There has obviously been little comprehensive planning whereby the responsibilities of any one agency for the care of its particular beneficiaries would be determined and carried out in relation to the responsibilities and programs of the other agencies. From the special standpoint of tuberculosis, the existing shortcomings reflect the lack of planning for an adequate treatment program coordinated with other control activities; they reflect the philosophy of handling each tuberculous beneficiary as an individual separated from the rest of his community.

In order to correct immediately the defects of the present system of multiple programs, a single federal agency should be established to administer the program of hospitalization and medical supervision of federal beneficiaries. This agency would be responsible for providing care for all federal tuberculous beneficiaries for whom care could not be provided in state and local facilities.

The separate hospital agency should have a competent medical director at the head. He should have an advisory board of experts in the various specialties, including hospital administration. The

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hospitalization of federal patients should be divorced from other activities of federal administrative agencies. To this agency should be transferred the tuberculosis hospitals of the Veterans Administration, Public Health Service and Bureau of Indian Affairs.

The Army and the Navy should discontinue the operation of separate tuberculosis hospital programs of their own. They should restrict their tuberculosis activities to diagnosis and the short-term care necessary before transfer of their tuberculosis patients to the single federal tuberculosis hospital agency. Such transfer of service personnel could be done without interfering with the policy of attempting to return to duty those who recover from such chronic diseases.

Federal prisoners with tuberculosis can not be treated in the ordinary tuberculosis hospital, of course, but under this plan, the medical staff for the tuberculosis service of the Bureau of Prisons should be supplied by the single federal tuberculosis hospital agency.

The hospital services of the single federal agency should be decentralized on an area or regional basis, with a Medical Administrator in charge of each area, also with an advisory group, similar to the present Dean's Committee plan. Non-medical personnel at all levels should be subordinate to and responsible to the respective medical administrators.

In order to provide integrated federal hospital services within each region as well as proper coordination of these services

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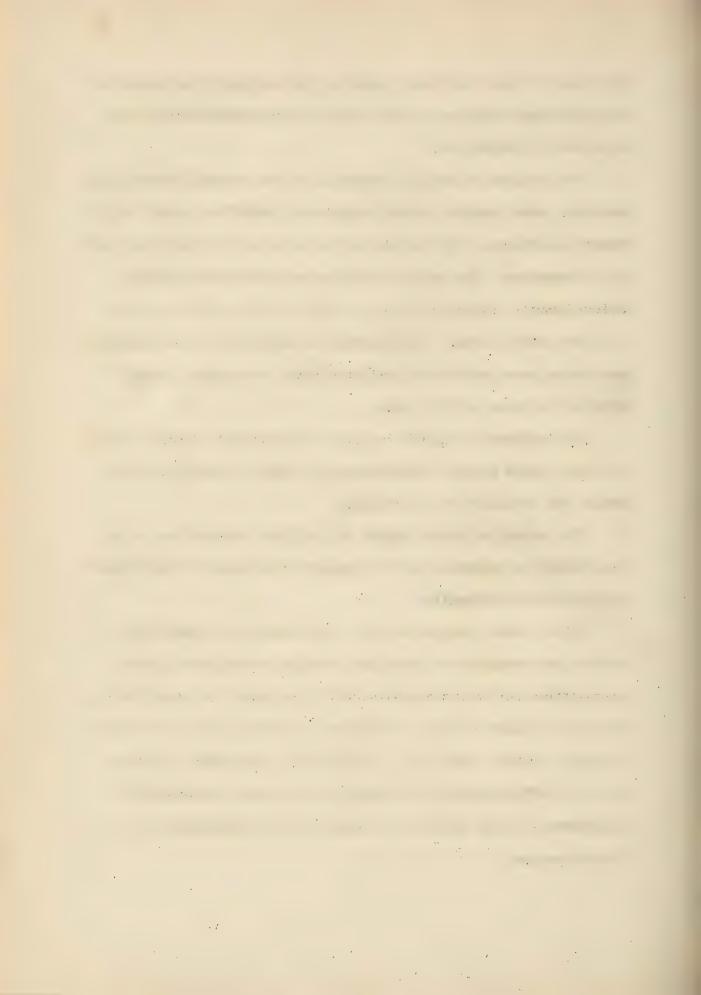
with those of state and local agencies, the regional plan should be developed along the lines of that adopted for nonfederal hospitals under the Hill-Burton Act.

With respect to the administration of the federal tuberculosis hospitals, each hospital should prepare and justify an annual budget request in advance, with the care of patients as the underlying basis for the requests. The budget should be reviewed by the regional medical hospital director and he in turn should be able to justify it at the central level. Funds should be allocated to each hospital for a whole year so that the available money for various expenditures can be known at all times.

The business or "hotel" aspects of tuberculosis hospital administration should be made auxiliary to the primary function of hospitals, the medical care of patients.

The presently limited supply of qualified tuberculosis physicians should be conserved and the present inter-agency "competition" in this respect elimitated.

An effective program should be established for recruitment, training and promotion of physicians through provision of career opportunities in the tuberculosis field; the media for accomplishing this should include clinical clerkships at the end of the third year in medical school, internships, residencies, postgraduate affiliations with other tuberculosis hospitals, staff and inter-hospital conferences, and the services of consultants in tuberculosis and allied diseases.



Intensive tuberculosis case finding programs through mass chest X-ray examinations should be instituted among groups of federal beneficiaries. This should include military and naval personnel, merchant seamen, Indians, federal prisoners and Veterans Administration hospital and clinic patients.

A more intensive research program in tuberculosis should be instituted.

The federal tuberculosis hospital program should be closely coordinated with the tuberculosis control programs of states and localities, through joint planning, conferences, exchange of information, mutual assistance, etc.

In summary, an integrated federal tuberculosis hospital program would make possible the provision of the highest quality medical care under a unified administration and uniform policy.

At the same time, it would markedly simplify the gradual transfer of responsibility for the care of federal beneficiaries to the states, because the single agency could obviously deal with the various states much more simply and expeditiously than the several independent and separate agencies could,

# General Conclusions

It is obvious that elimination of the duplications, inconsistencies and inefficiencies which are inevitable in the present system of several independent federal tuberculosis programs will result in definite economy as well as in better services. nen, and the second problem of the second and the s

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It may not be quite so obvious but it is, nometheless, evident that eventual transfer to state and local governments of the major part of the federal tuberculosis activities will also result in the long run in definite economy, because for the same federal expenditures the services provided will be better in every way.

Not alone the federal beneficiaries but all people in the country will benefit.

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#### SUGGESTED FUTURE STUDIES

- 1. Development of detailed plans for integration of the federal tuberculosis activities including the proposed regionalization.
- 2. Estimation of tuberculosis facilities needed in the future for:
  - (a) Federal beneficiaries.
  - (b) All tuberculosis patients; estimation of this to be done jointly with states.
- 3. Development of plans jointly with the states:
  - (a) To make possible the treatment of federal tuberculosis beneficiaries in state and local facilities.
  - (b) To transfer gradually and progressively tuberculosis patient care to state and local facilities.
- 4. Detailed analysis of the operating costs of federal hospitals in order to determine the basis for the possible elimination of nonessential activities and expenditures, especially those of non-medical nature. This should include the establishment of appropriate ratios of personnel of all types for most efficient operation of the hospitals.
- 5. Further study of the factors influencing the shortages of tuberculosis physicians and development of steps to remedy the existing
  situation.
- 6. Development of additional research studies in the clinical, epidemiological, and socio-economic aspects of tuberculosis, integrated with and extended through grants in aid to the tuberculosis programs of states, universities and other agencies. Because of the special significance of the tuberculosis problem in the non-white races, it should receive particular attention in the field of research as well as in the training of professional personnel.

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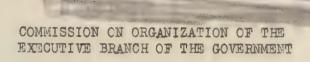
APPENDIX E

REPORT OF THE
SUBCOMMITTEE ON PSYCHIATRY AND NEUROLOGY
COMMITTEE ON FEDERAL MEDICAL SERVICES

William C. Menninger, M. D.

Jack R. Ewalt, M.D., Staff





#### APPENDIX E

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November 1948



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# REPORT OF THE SUBCOMMITTEE ON PSYCHIATRY AND NEUROLOGY COMMITTEE ON FEDERAL NEDICAL SERVICES

# I. Special Problems in the Federal Medical Services

In the ideal medical service of the federal government, the chief functions should be concerned with coordination, planning, the setting and enforcement of standards, demonstrations of treatment methods, and the stimulation of training and research through subsidy. Except for very limited areas, as illustrated by the military or in the case of total wards of the government, the federal medical services should not be an operator in the field of medical care. No sudden change can be made from the present system, however, and also it seems essential to set forth some of the problems we know to be inherent in our current federal medical services. The following points should be included.

A. Isolation from the Community Presumably in a democracy the people themselves control the services that benefit them.

In a community any type of medical service sponsored by the federal government is likely to be regarded as something apart. There is an inevitable tendency for the community to take little interest in it and often its membership takes little interest in the community. Rarely does the community participate in any tangible way in its management but on the contrary the staff of such a unit tend to regard their stay in the community as temporary, involving no sense of responsibility to the local community beyond their technical work.

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- B. Care is given to a special class of people All agencies providing federal medical service apply to a necessarily limited and specified group. Thus federal medical services become a discriminatory practice, whether it is in the care of veterans, the care of federal employees, the military, or in the care of lepers.
- C. "Receiving something for nothing." In any free system of medical care there is inevitably a tendency to abuse the privilege on the part of those receiving it. This type of system encourages what technically is regarded as the secondary gain in illness, including the acceptance of illness as an escape method and the prolongation of illness for the same purpose. It is most vividly illustrated in the experience of our system of pensions. Studies indicate clearly that the period of hospitalization in most governmental hospitals is far longer for the same type of disturbance than in private hospitals where the individual pays his way. In part this may be due to red tape in federal institutions but it is chiefly attributable to this established psychological principle. Furthermore, many patients are admitted to hospital who in civilian life would be treated as outpatients.
- D. Impersonalness Professional workers in federal institutions tend to have a much less personal interest in their patients than is true in the private practice of medicine. This often leads to ignoring the costs and routinizing the treatment.

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- E. Administrative red tape In every federal medical unit there is an inordinate amount of red tape in contrast to the comparable civilian unit. The administration, therefore, requires a considerable part of the time of professional personnel which could be reduced by adequate stenographic and clerical help. The "disposition" of patients in the Army, i.e. their discharge (CDD) from the service during the war, often required an excessive period of time, waiting for Board action, "clearance", approval at various levels, etc.
- F. Morale of government employees Even professional personnel often become "clock punchers," and forty-hour-a-week workers. There are no established incentives such as exist in private enterprise. In some government installations "over-time" work is prohibited. Minimal rather than maximal efforts thus tend to be made.
- G. <u>Personnel</u> Federal medical service to date has almost insoluble problems with regard to personnel, related to many factors. These include:
  - 1. Inadequate salary in contrast to the opportunities in civilian practice.
  - 2. An hierarchical system which often completely throttles the younger, more alert progressive professional person because of the stupidity of a well-entrenched, and perhaps higher-ranking, superior. Most important is that the top positions are always entirely administrative, often preventing the brilliant clinician from ever

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achieving the same level of status or pay and frequently placing in these top administrative positions individuals who have minimal clinical ability but often complete authority over the clinicians.

- 3. The tendency to isolationism both from:
  - a. The community which is particularly important in the case of the professional worker's family;
  - b. The professional group with which the individual wishes to become identified.
- 4. The lack of permanency due to frequent moves in location, often without consideration of the wishes of the individual.
- 5. The limitations imposed by the requirement to "remain within the budget," and the feeling of total helplessness to change this.
- of its employees and the establishment of a teamwork among them. When a sudden reduction in the personnel ceilings is announced from the central office, there are several inevitable results: The manager or commanding officer of that hospital loses face as the leader who has encouraged the group to work with him; the work and effectiveness of the hospital diminishes despite public statements that the medical care "will not suffer"; a cut is always a threat to those workers who remain to feel in constant fear that another blow will fall sooner or later.

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- 7. Related to the last point is the fact that often cuts in personnel are made on purely a statistical basis without consideration of the particular problems of each hospital (training programs, specialized types of patients, special programs, experimental and research work), without consideration to the type of hospital (the efficient many-storied hospital in contrast to the sprawling army type hospital), and apparently on the assumption that employees of a hospital are an accumulation of bodies or an aggregate of dissociated individuals.
- H. Change of policy A major handicap in federal medical installations is change of policy, particularly with shifts in administration. A program of education or research always is initiated with a large question as to its permanency because of year-to-year budgets and personnel ceilings, inability to make commitments beyond one year, changes in administration, and changes through congressional action.

## II. Current Status of Psychiatry and Neurology

- A. Summary of the extent of the nation's psychiatric problems
  - 1. Mental ill health and personality disorders represent the number one health problem of America as judged by the following facts:
    - a. The number of potential persons involved is very great, particularly in acute periods of social stress.

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- b. The number of psychiatric patients exceeds the number with any other type of illness.
- c. Nearly 50% of all hospital beds in America are required for this group of illnesses (662,452 of total of 1,425,222 beds.)
- d. Proportionately the shortage is the most acute of any group of medical personnel, as judged by such groups as the FSA's National Health Assembly, various agencies in the federal government using this personnel, by careful surveys indicating current community needs. Available: 4,500 psychiatrists; minimal estimated need: 10,000.
- e. Proportionately the amount invested in research is the smallest of any medical specialty. (Ewing Report: Currently \$2,000,000 out of \$120,000,000 for medical research.)
- f. Personality disorders were the cause of 37% of all draft rejections in World War II. This represents 12% of all men coming to the draft examination.
- g. They were the greatest single cause of lost military manpower, representing more than 50% of all men lost from the service.
- h. The need for treatment facilities, including both hospitals and clinics, is probably more acute than in any other medical specialty.

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- i. The supply of tested knowledge in psychiatry, especially in the area of prevention, is probably the most limited of all the medical specialties.
- in money approximately 40% of the total
  federal government budget for health and from
  one-sixth to one-third of the state budgets in
  our larger states. (New York allows \$52,000,000
  out of a total budget of \$165,000,000; Massachusetts allows \$16,000,000 out of a total budget
  of \$58,000,000.)
- The nature of the psychiatric problem In considering mental health and ill health, both the medical profession and laymen must revise their concept of disease as it applies to man's adjustment. Man is incapacitated not only by bullets and bacteria, cancer and trauma, but by psychological stresses, which account for 50% of the physical complaints seen by physicians. Mental health is concerned with how men feel, think and act and, therefore, is a problem not only of physiology and anatomy but also of psychology and sociology. Any plan for federal mental health service must take in the total purview of human relations which contribute to or cause emotional distress, insecurity, unhappiness and therefore directly affect man's efficiency, satisfaction and social

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relationships. The nature of mental illness differs radically from that of many physical illnesses in its chronicity and, therefore, in the expense of care and treatment. For this reason much of the practice of psychiatry became a system of state medicine many years ago.

- 3. The present federal medical program in psychiatry and neurology
  - a. Four government agencies provide treatment programs

     Federal Security Agency, Army, Navy, Veterans

    Administration. To this the Air Force may be added shortly. There is an overlap of administrative procedures, duplication of staff and of effort, with minimal coordination.
  - b. There is no liaison with any other government agencies concerned with policies and practices affecting or dealing with mental health.
  - c. There is an acute shortage of personnel, and competition between agencies for personnel, with minimal consideration given to civilian needs (except for Public Health Services administration of the National Mental Health Act.) In general the practice is "each agency for itself".
  - d. Each agency maintains a separate training program

    for its own professional personnel with minimal use

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of civilian training centers. In this connection the Veterans Administration has done great service in greatly augmenting the current training opportunities in psychiatry, neurology, clinical psychology, social work and psychiatric nursing. Because many persons so trained return to civilian jobs this program does materially aid in meeting civilian needs for personnel.

- e. Research is minimal with no central direction or coordination.
- f. There are many duplications in consultants as well as consulting Boards.
- 4. There is no federal agency interested in the problem of mental health in the nation as a whole, although the Public Health Service is making an important beginning contribution through grants to states under the Mental Health Act.

#### B. Federal neuropsychiatric services

1. Summary There are five federal services in psychiatry and neurology: Veterans Administration, Army, Navy, St. Elizabeths Hospital and the Public Health Service. There is no integration or official intercommunication among these services and each agency operates independently.

The Federal Security Agency maintains no administrative or clinical correlation between St. Elizabeths

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Hospital and Public Health Service (or the Children's Bureau which maintains a mental hygiene unit). The Hospital Division of Public Health Service has psychiatric units in some marine hospitals; in conjunction with the Bureau of Prisons it operates psychiatric services in some federal prisons; it supervises the Federal Employees Health Services.

The Veterans Administration is the largest of the Federal Agencies in terms of number of neuropsychiatric patients cared for. It operates psychiatric hospitals, psychiatric divisions in general hospitals and outpatient clinics. It maintains a psychiatrist in each regional office.

The Army and Navy operate psychiatric services in general hospitals. The Army maintains outpatient clinics in basic training camps, psychiatrists in disiplinary barracks and assumes some responsibility in draft selection.

In recent months an unofficial liaison has been established among the various services to coordinate psychiatric practice through joint meetings between chiefs of psychiatry in each service.

In June 1948, 45% of all patients hospitalized in federal hospitals and psychiatric and/or neurologic disorders. For the nation as a whole, approximately 50% of all hospital beds are for psychiatric disorders.

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In the United States, 94% of all psychiatric patients in hospitals are in hospitals operated by either federal or state governments; the balance of 6% are in private psychiatric hospitals and university psychiatric teaching hospitals.

### 2. The Veterans Administration

- a. Administration In the central office the Division of Neurology and Psychiatry is competently staffed, serves as a part of the Professional Service, but along with the entire medical department suffers because the important services of supply, construction, finance, special services, etc. for medical activities are not under medical control. This divided responsibility results in a poor administration organization, interfering with morale and efficiency in the VA hospitals. There is inadequate authority in the hands of the Chief Medical Director. The medical service suffers under the curse of a non-medical inspector's unit.
- b. Facilities and patients There are 34 psychiatric hospitals plus psychiatric sections in all general hospitals. As of June 30, 1948 there were 54,907 psychiatric patients in these hospitals representing 52% of the total number of patients.

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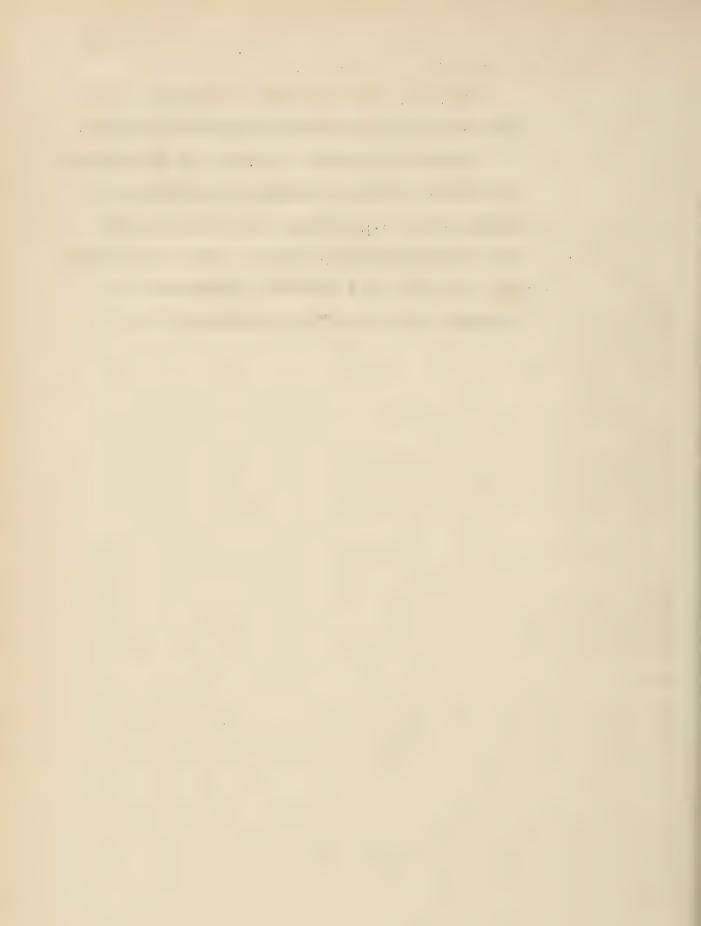
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Outpatient clinic facilities numbering 57 handled approximately 102,311 different patients during 1947-48.

Increase in the number of patients in the hospitals and clinics is because of increase in accumulation of chronic patients in hospitals, higher admission rate due to better recognition, increased number of referrals.

c. Cost The cost of all psychiatric hospital care has increased as may be seen from the following table.



Expenditure for Maintenance in Hospitals for the Long-Term Care of Psychiatric Patients, by Type of Hospital, for the United States: 1945 to 19474

| Type of Hospital and Year                                    | Total Expendi-<br>ture for Main-<br>tenance | Average Daily Resident- Patient Population | Per Capita<br>Expenditure |
|--|---|--|---------------------------|
| 1947   |   |  |                           |
| All Hospitals  | <b>\$395,000,000</b>                        | 540,000                                    | \$ 731                    |
| State, county, and city hospitals !                          | 264,000,000                                 | 481,000                                    | 549                       |
| hospitals <sup>2</sup> / Private hospitals <sup>3</sup> /    | 96;000,000<br>35,000,000                    | 45,000<br>14,000                           | 2,133<br>2,500            |
| 1946 All Haspitals   | 292,000,000                                 | 525,000                                    | 556                       |
| State, county, and city hospitals                            | 206,000,000                                 | 468,000                                    | 440                       |
| hospitals 2/   |   | 43,000<br>14,000                           | 1,279<br>2,214            |
| 1945 All Hospitals   | 241,000,000                                 | 513,000                                    | 470                       |
| State, county, and city hospitals Veterans' neuropsychiatric | 180,000,000                                 | 460,000                                    | 391                       |
| hospitals2/  | 33,000,000                                  | 39,000                                     | 846<br>2,000              |
|  |   |  |                           |

Based on data from the Annual Census of Patients in Mental Institutions.
 Based on fiscal year data furnished by the Veterans Administration.
 Based on tabulation of data for those hospitals reporting information or operating costs for the American Hospital Association Directory.
 From News Release, Mental Hygiene Division, USPHS, Sept. 26, 1948.

The increase in per diem cost is a result of (1) increase in all hospital costs for food, salaries, drugs, building, etc.; (2) giving a better class of medical care in veterans psychiatric hospitals. The care in veterans hospitals is on the average much better than that given in the large state hospitals but is below the standard given in small university psychiatric clinics and some better private hospitals of the country.

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- d. Personnel There is an acute shortage of all types of trained personnel psychiatrists, neurologists, psychologists, psychiatric social workers, nurses, aides, and according to VA projections the shortage will become even more acute.
- e. Training The Veterans Administration has been making superb efforts to develop training programs for psychiatric and neurologic residents, for clinical psychologists, psychiatric social workers and psychiatric nurses. Although there was no residency training in 1945 there are now 357 psychiatric residents and 158 vacancies for residents in VA hospitals. Most of these vacancies occur in isolated hospitals or where dynamic psychiatry is not taught. As such, they are of dubious value. All programs are carried out with the direct cooperation and supervision of leading university medical schools and training centers.
- f. Treatment The general level of patient care has improved greatly in the VA in the last year. Early hospitalization is encouraged so that illnesses may be treated in the acute phases, and there is increasing use of mental hygiene clinics for patients not requiring hospital care. Outpatient clinics can treat only service connected disabilities (except for follow-up cases). Merely this emphasis on early and

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intensive treatment on an outpatient basis has reduced the number of admissions and increased the recovery rate. Such clinics are run both under the direct management of the Veterans Administration and through contracts with private clinics and private psychiatrists.

- g. Purchased bed space The VA utilizes bed space in other government hospitals and in some civilian hospitals when available. Shortage of psychiatric personnel makes it impossible to staff even current facilities. Purchase of bed space in other government hospitals however is used as justification for other agencies to build more hospitals.
- No. Research Psychiatric research sponsored by the Veterans Administration under the advice of the Committee on Veterans Medical Problems of the National Research Council in 1947-48 has amounted to 12 grants amounting to \$335,663, representing 38% of total funds for research recommended by this committee. Research is definitely secondary in the VA program carried on in part by Veterans Hospitals and in part on contract with other institutions or individuals. To date there have been no research projects in the field of prevention.
- 3. Federal Security Agency This agency operates two psychiatric services, St. Elizabeths Hospital and

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Public Health Service although there is no relation between these.

a. St. Elizabeths Hospital Care for patients from
the District of Columbia and certain classes of
federal beneficiaries who by reason of their federal
connection are deprived of state citizenship. Military personnel formerly cared for are now excluded.

St. Elizabeths has a capacity of 6,012 beds and an average census of 6,650 patients. The hospital operates no mental hygiene clinic.

Follow-up care of the patients is done by the Social Service Department and on rare occasion by the local mental hygiene clinic in the city.

The hospital has a residency program in addition to postgraduate students in psychiatric nursing, psychology and social service. Several research projects are being carried on in the institution. The professional staff is numerically below standards established by The American Psychiatric Association, but compares favorably with other federal hospitals and is better than most state institutions. There is a large number of chronic patients.

The administrative organization is a separate bureau under the Federal Security Agency and is unrelated to other federal medical agencies or programs.

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### b. The Public Health Service, Division of Mental Hygiene

- (1) Administration The central office is answerable to the Bureau of Medical Services and is headed by a chief with a number of assistants in psychiatry and the related fields of clinical psychology, social work and psychiatric nursing. There are psychiatrists in the branch offices insofar as personnel can be found to fill these positions. Currently the mental hygiene division has 23 psychiatrists, 18 of whom are diplomates of the Board. They currently need approximately 50 psychiatrists and have a corresponding shortage in ancillary personnel.
- (2) Functions The Division (a) serves as an advisor to the Surgeon General of the Public Health Service in the area of mental health; (b) operates two hospitals for psychiatric and narcotic patients, one at Lexington, Kentucky and one in Forth Worth, Texas, which cared for a combined average of 2,036 patients in 1948, and have a combined capacity of 2,512 beds; (c) supervises the psychiatric care of federal prisoners, with a psychiatrist (if available) stationed in each federal penitentiary and supervises the operation of a special unit in Springfield, Missouri; (d) supervises the psychiatric sections of marine hospitals (functions under

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(c) and (d) are not directly under the management of the Mental Hygiene Division); (e) supervises the operation of the National Mental Health Act.

## (3) National Mental Health Act

- (a) The National Mental Health Act passed by Congress in 1946 provided for
  - (1) The support of training in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing both through provision of grants to institutions and through individual stipends. Grants were made for the year 1947-48 to 87 institutions in the amount of \$1,573,597; stipends were granted as follows: 71 in psychiatry for \$219,000; 54 in clinical psychology for \$94,932; 62 in psychiatric social work for \$111,000; 82 in psychiatric nursing for \$145,561.
  - (2) Subsidy of research and research fellowships in universities and hospitals. During the first year of operation of the Mental Health Act 28 of the projects were financed through funds from this source for a total amount of \$373,664.95. Twenty reseach fellowships were granted, amounting to \$64,822.
  - (3) Grants-in-aid to 46 states for mental health work under the auspices of the Mental Health Act. These amounted to

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\$1,653,454 in the 1947-1948 program. This emphasis or preventive psychiatry, with the establishment of community clinics, with public education at the state level, and with the establishment of a mental health authority in every state, has been a very progressive step.

(b) The administration of this act by the Mental Hygiene Division has been through the aid of a nonsalaried group called the National Mental Health Advisory Council of 6 members aided by some 60 consultants, advising the Surgeon General with regard to these grants. These consultants do not serve the PHS Mental Hygiene Division except to pass on requests for funds under the Mental Health Act.

#### 4. The Army

includes a division supervising psychiatry and neurology which is on a per with the medical and surgical divisions. It has a headquarters staff of four officers with current authorization to be increased to 11. The consultant system during the war with army psychiatrists at service command (now army) and theater levels, has disappeared because of lack of personnel. Currently there are civilian neuropsychiatrists designated as consultants in each of the six Army areas but rarely are

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- they used by the Army surgeons. Occasionally they make inspection trips at the request of the S.G.O.
- b. Functions Psychiatric and neurological services are maintained in the nine general hospitals, and sections under the chief of medicine in station hospitals both in U.S. and overseas. In addition a mental hygiene clinic is maintained in each basic training camp. As of June 1948 there was an average daily census of 1,687 psychiatric patients (representing 11.7% of all patients) for 2,291 NP beds in Army installations. Chronic patients are transferred to the Veterans Administration or to civilian institutions, depending on their eligibility.
- c. Personnel The Army has 12 psychiatrists who are certified by the American Board and 91 others (including ASTP) who have had insufficient experience as yet to qualify them. The disciplines of clinical psychology (a part of the neuropsychiatric service), psychiatric social work and psychiatric nursing are also acutely short of personnel for current needs.
- d. Training The army has inaugurated a residency training program for 53 psychiatrists in 3 of the general hospitals and maintains a school for the training of clinical psychologists, psychiatric

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- social workers, and ward attendants at Fort Sam

  Houston, Texas. Very limited use has been made of
  civilian training centers because of a lack of personnel available to attend them.
- e. Research A limited research program has been possible.

  Much more investigation has been carried on in the

  care of burns than in the prevention of neuropsychiatric disorders. Related projects of special
  interest to psychiatry are being carried on under

  the auspices of the Committee on Human Resources
  of the Research and Development Board.

### 5. The Navy

- a. Administration The Neuropsychiatric Branch of the Bureau of Medicine and Surgery advises the Surgeon General and the Policy Board on matters related to psychiatric problems in the Navy. This is currently staffed by one physician and one psychologist. The Navy did not use a consultant system for the care of patients during the war and has no consultants (except for 19 used for teaching purposes) in Navy installations at the present time.
- b. Program The Navy operates psychiatric units in 21 hospitals the average census of which was 1,212 psychiatric patients in 1948. The acute patients are treated and chronic patients are transferred to the

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- Veterans Administration or to civilian hospitals.

  Psychiatric services are provided in four boottraining camps.
- c. <u>Personnel</u> The Navy is acutely short of trained personnel, currently having 15 psychiatrists qualified by the American Board and 61 (including V-12) as yet not able to qualify.
- d. Training The Navy has established residency training programs with 17 officers in training in its

  Bethesda and Philadelphia hospitals. Like the Army,
  they have had difficulty in filling these jobs.

  They have provided for training in civilian centers
  for 13 commissioned officers on detached service.

  They make liberal use of civilian consultants for
  their teaching centers.
- e. Research There is no research in psychiatry in the Navy under the supervision of psychiatrists. On the other hand, the Office of Naval Research has contracted for much more extensive research in the area of man-power and morale than has the Army.
- f. Coordination The Chiefs of psychiatry in the Army and Navy constituted a committee under the Hawley Board to bring forth recommendations, none of which, however, have been accepted by the Navy with the possible exception of nomenclature.

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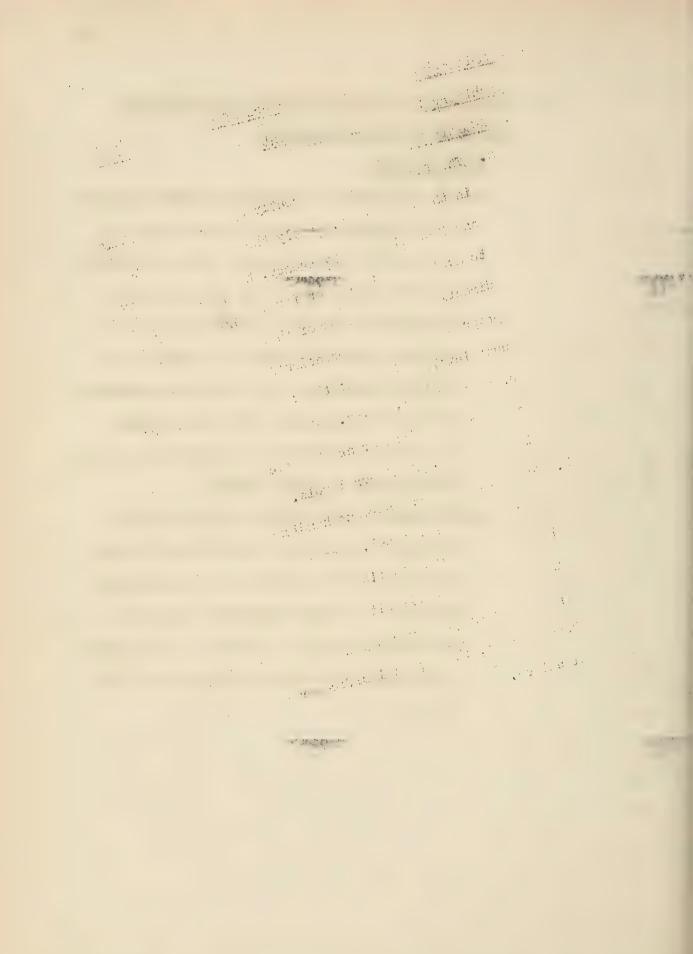
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# C. Compiliation of the total picture of neurology and psychiatry in federal government

#### 1. Administration

- a. The four agencies currently operating hospitals in the government, namely the VA, Army, Navy, and Federal Security Agency, have no authority to avoid competition or for joint planning, direction or operation of their psychiatric programs except for occasional informal and unofficial meetings of the chiefs of psychiatry of these four agencies. There is a minimal coordination, insofar as the psychiatric program is concerned, at higher levels.
- b. Each agency faces enormous handicaps in the shortages of personnel, restrictions through budgets, relative position in the organization and many other wheels within the wheels that apparently frequently get jammed at the central headquarters, the regional office or the local situation.



| Agency                                 | Number<br>of NP<br>Hospitals | NP Beds<br>in General<br>Hospitals | Total NP<br>Patients | Total All<br>Patients | Percent NP<br>Patients |
|--|------------------------------|------------------------------------|----------------------|-----------------------|------------------------|
| TOTAL                                  | 36                           | 12,535                             | 64,677               | 142,563               | 45.4                   |
| Veterans Administration                | 33                           | 8,135                              | 54,790 b             | 103,576               | <b>52.9</b>            |
| Army                                   | -                            | 2,291                              | 1,755                | 12,542                | 14.0                   |
| Navy                                   | -                            | 1,816                              | 1,862 <u>c</u>       | / 12,800              | 6.7                    |
| Public Health Service (Mental Hygiene) | e <b>2</b>                   | -                                  | 925                  | 1,933                 | 47.9                   |
| Public Health Service                  | ee <b>-</b>                  | 293 <u>a</u> /                     | 217                  | 5,367                 | 4.0                    |
| St. Elizabeths                         | 1                            | -                                  | 6,345                | 6,345                 | 100.0                  |

a/ Marine hospitals.

b/ Includes 2,171 patients in non-Veterans Administration hospitals.
c/ Navy does not hospitalize all NP patients in its general hospitals;
this figure does include those hospitalized in Naval Medical Unit,
Public Health Service hospital, Ft. Worth, Texas.

d/ Includes 12,286 patients in non-Veterans Administration hospitals.

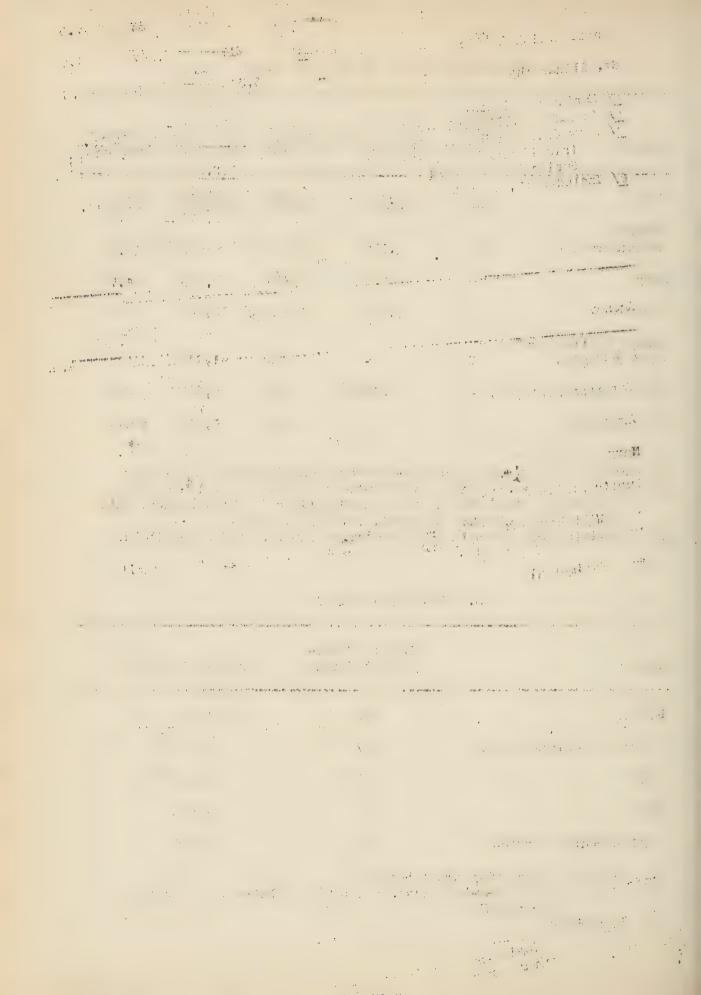
#### 3. OUTPATIENT CLINICS

| Agency                  | Number of Out-<br>patient Clinics | Patients 1947-1948 |
|-------------------------|-----------------------------------|--------------------|
| TOTAL                   | 65                                | 122, 254           |
| Veterans Administration | 57                                | 102,311**          |
| Army                    | 4*                                | 12,000***          |
| Navy                    | 1                                 | 6,505              |
| Public Health Sorvice   | 3                                 | 1,418              |

\* Will have nine when draft begins.

\*\* Visits two and one-half times per patient (basis of one visit per month).

\*\*\* Estimated.

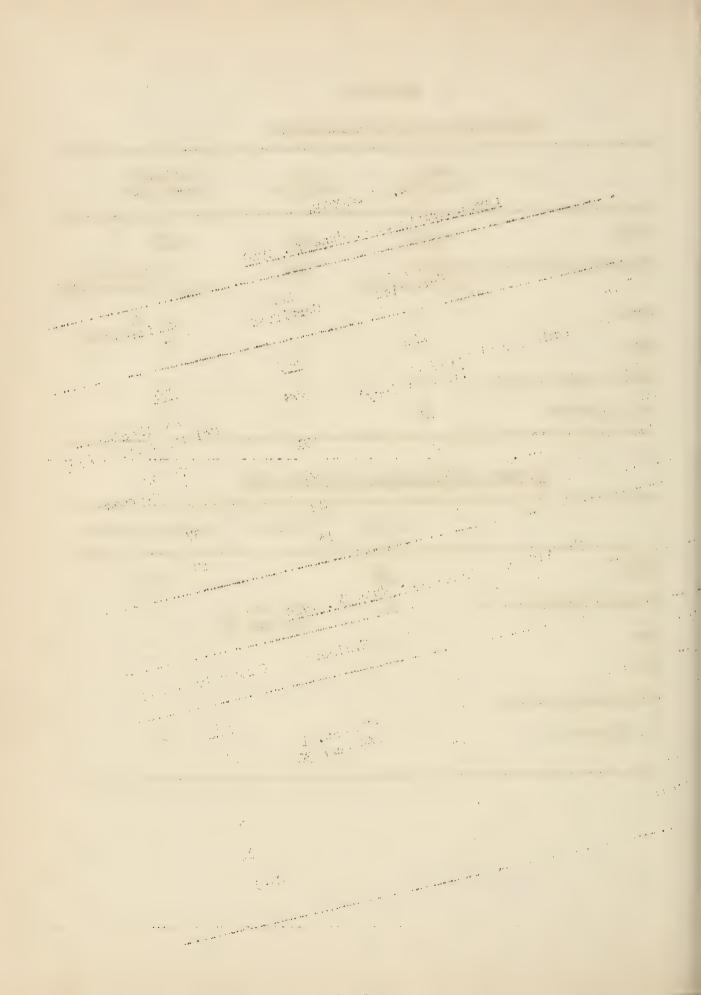


4. PERSONNEL
Psychiatrists as of June 30, 1948

|                        | Board<br>Certified         | Not<br>Certified | Unfilled<br>Current Need            |
|------------------------|----------------------------|------------------|-------------------------------------|
| TOTAL                  | 384                        | 587              | 897                                 |
| Veterans Administratio | n(NP)315<br>(15 Neurology) | 398              | 700 (Needed<br>Ceiling permits 250) |
| Army                   | 12                         | 91               | 75 ZI<br>15 overseas                |
| Navy                   | 16                         | 60               | 15 overseas<br>60                   |
| Public Health Service  | 20                         | 23               | 37                                  |
| St. Elizabeths         | 21                         | 15               | 10                                  |

Clinical Psychologists - June 30, 1948

|                         | On Duty | Trainees    | Currently Needed |
|-------------------------|---------|-------------|------------------|
| TOTAL.                  | 302     |             | <u>634</u>       |
| Veterans Administration | 241     | 670 Oct. 1  | 500              |
| Army                    | 32      | 469 June 30 | 58               |
| Navy                    | 1       |             | 50               |
| Public Health Service   | 25      |             | 16               |
| St. Elizabeths          | . 3     |             | 8-10             |



4. PERSONNEL (Continued)
Psychiatric Social Workers, June 30, 1948

|   | On Duty              | Currently Needed       |
|---|----------------------|------------------------|
| TOTAL                                       | <u>543</u>           | 531                    |
| Veterans Administration                     | 495                  | 450 (est.)             |
| Army  | 24                   | 51                     |
| Navy American Red Cross<br>naval hospitals: | supplied all psychia | tric social workers in |
| Public Health Service                       | 15                   | 26                     |
|   | 9                    | 4                      |

| TOTAL                   | 3,266 | 2,539        |
|-------------------------|-------|--------------|
| Veterans Administration | 2,700 | 2,000 (est.) |
| Army                    | 137   | 263          |
| Navy                    | 63    | 175          |
| Public Health Service   | 103   | 39           |
| St. Elizabeths          | 263   | 62           |
|                         |       |              |

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## 5. TRAINING PROGRAMS as of June 30, 1948

| · <u>· ·</u><br>3<br><u>0</u> | Cotal Psych<br>Residencies<br>able under<br>Control<br>Psychiatry | Agency | in Train<br>under Ag<br>Control | Neuro- | Residents in<br>Civilian<br>Training<br>Institutions |
|-------------------------------|---|--------|---------------------------------|--------|--|
| TOTAL                         | 694   | 46     | 537                             | 40     | 27   |
| Veterans Administration       | on 572  | . 46   | 421                             | 40     | 0  |
| Army                          | 59  | . 0.2  | : 53                            |        | 2  |
| Navy                          | .39   |        | 17                              |        | 18   |
| Public Health Service         | No ceili  | ng     | 17                              |        | 7  |
| St. Elizabeths                | 24  |        | 29*                             |        | 0  |

<sup>\*</sup> Includes three Navy, two Public Health Service, two "volunteers" from foreign countries.

#### 6. RESEARCH PROGRAMS

| Veterans Administration | 12 Projects for \$335,663.  |
|-------------------------|---|
| Army                    | Eight Projects for \$225,000 (fiscal year 1949)   |
| Navy                    | Eight Projects now being conducted by universities and non-profit organizations, cost figures not available.                        |
| Public Health Service   | 28 Grants for \$373,664.95 in 1948-49; \$63,879 for drug addiction and \$64,822 for fellowships under National Institute of Health. |
| St. Elizabeths          | No specific budget - 15 projects.   |

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7. Prevention None of the federal services has a preventive psychiatry program per se. The Mental Hygiene Division of the Public Health Service has developed considerable informational literature available to the public. The Veterans Administration and the Army conduct outpatient clinics which are primarily for treatment: in the Army the psychiatrist is responsible for giving advice to commanding officers regarding problems of morale. Through grants-in-aids to states. the Public Health Service promotes mental hygiene. The Navy has no organized program; psychiatrists in training stations act as consultants to the training stations in matters of mental hygiene. The head of the Neuropsychiatric Branch in the Bureau of Medicine and Surgery is consulted in connection with policies referable to prevention.

# III. Recapitulation of Inadequacies in the Practice of Psychiatry and Neurology in the Present Federal Medical Services

#### A. Administration

- 1. Giving remedial medical services to certain groups of government beneficiaries represents a discriminatory practice which may be inevitable, but the isolation and emphasis on discrimination could be minimized by wider utilization of civilian hospitals, clinics and physicians.
- 2. Federal medical installations are notorious for being isolated from the community and are important to the

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- community chiefly because of the economic benefit to the merchants, and because they provide employment. Steps might be devised to minimize this isolation.
- 3. The duplication of professional personnel is particularly conspicous in headquarters and regional offices. There is even duplication in certain local situations where two hospitals exists in the same community. Specialized treatment centers would save personnel and facilities.
- 4. There is a lack of standardization of policies and methods, with much duplication of circulars, directives, etc.
- 5. There is a conspicuous lack of authority for cooperative action between the agencies, and each is in some degree competitive with the others for personnel and budgets.
- 6. Not infrequently there is a subordination of the professional to the lay director and in other instances
  a system which permits an inadequate superior to dominate and direct a much more alert, younger professional
  person, with no choice or escape for the younger person. This is tied in with rigid regulations regarding
  seniority, rank, promotion policies.
- 7. Top positions are always for administrators who are denied an opportunity for clinical work. Correspondingly, it is impossible for the clinician to achieve equal status and rank.

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- 8. There is no inter-agency use of personnel.
- 9. Except in the Veterans Administration and less so in the Army, there is a minimal use of civilians as consultants. It is believed that much help could be obtained by part-time and full-time civilians who would not be required to come into the hierarchy or make themselves career men.
- 10. Since the war there has been a much wider use of consultants, but in many instances there is evidence that available civilian facilities and personnel are completely ignored.
- ll. Most serious are the many areas other than current federal medical services which are totally uncovered and are given little or no consideration. Except for the Public Health Service's administration of the Mental Health Act, all services are primarily clinical. There is some secondary interest in research. As a result there are these grossly uncovered areas in which the government should give leadership:
  - (a) Preventive psychiatry receives minimal attention from any source.
  - (b) There is no uniform or united public education effort, and in fact very little effort made by an agency.
  - (c) There is no unified national leadership considering the total problem of the nation's mental health.

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- (d) There are no liaisons established with any of the other government departments, even though many of these departments are vitally concerned with personnel and other policy formation that affect mental health.
- (e) There is no federal agency giving any consideration to or assuming any responsibility for the extremely backward status in state hospitals.

#### B. Clinical Practice

- 1. Inadequate beds Under present practices there is an acute need for more psychiatric beds. This situation may change, depending on the policy of the government regarding treatment for service connected versus non-service connected disabilities. This shortage is related to the average of 17% overcrowding in our state hospitals for the nation as a whole, with several states running as high as 30% to 50% overcrowding.
- 2. Outpatient clinics The Veterans Administration has made a good start in developing outpatient clinics for psychiatric treatment but there is a totally inadequate number of such facilities even for veterans.

  (These clinics are quite separate from a second system of clinics established for the sole purpose of making examinations for claims and pension readjustments.)

  They do materially decrease the amount of hospitalization required, but many veterans with nonservice

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- connected conditions enter hospitals who would not need to if they could be given treatment in an outpatient clinic. Except for the Veterans Administration there is no use made of civilian outpatient clinics.
- 3. Even though approximately 50% of all patients who consult physicians are suffering primarily from emotional disorders, there is woefully inadequate education in psychiatry for all physicians. The teaching of this subject is improving in medical schools but except for some minimal efforts on the part of the Army there are no established refresher courses in psychiatry for physicians now in practice. Such courses could be arranged in civilian training institutions.
- 4. Since all federal medical installations are somewhat isolated from civilian medicine (although this has improved since the war), a definite program should be developed for the participation of the federally employed physicians (and related professional workers) in medical education, in medical organizations, and in medical meetings.
- 5. There is a great lag in the appreciation of the medical profession for the inter-discipline needs in practicing good psychiatry. Professional workers in clinical psychology, psychiatric social work and psychiatric

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nursing, are essential to develop an effective psychiatric team. These groups are highly trained professional workers.

#### C. Personnel

- Duplication of personnel has been indicated under III
   A-3 above.
- 2. Study needs to be made of the personnel management of federal medical and other professional employees in order to provide more attractive opportunities, greater incentive, more security, greater opportunities for individual achievement and advancement and more permanency. The shortage of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses is acute. The only hope is giving a very high priority to the subsidy of civilian training institutions.
- 3. Professional workers should be removed from the civil service system: Employees Health Service, St. Elizabeths, psychologists and social workers in the VA, etc.

#### D. Training Program

1. There is no coordinated system in the training programs for professional personnel sponsored by the various federal medical services. VA has done an outstanding job but some of its residencies are inadequate as to quality; some of them are not filled.

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- weak for lack of competent teachers. The university and other outstanding civilian training centers could do more training were they sufficiently subsidized.
- 2. The current projected needs cannot be met by the current output of training courses now in progress, in psychiatry, clinical psychology, social work and psychiatric nursing.
- 3. Medical schools are not sponsored or supported by the federal government although under the National Mental Health Act, subsidy will probably be available to the departments of psychiatry. On the other hand, the shortage of physicians in the nation, especially the shortage of psychiatrists, is the concern of the government, if for no other reason than the major needs within the present federal medical services. Currently, psychiatry is inadequately taught in many of our medical schools so that the physician graduates with little, if any, understanding of personality difficulties or of the emotional factors in disease. The financial dilemme of privately endowed medical schools can probably be relieved only by federal subsidy.
- 4. Heroic measures must be taken to provide far more subsidies for the development of new and the improvement of existing graduate training centers in psychiatry and related fields and for stipends for individual students. The only help in this area has come through

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the thus far meagre funds from the National Mental Health Act. (Labor-FSA Supplementary Appropriation Act of 1949, which included funds for the Mental Health activities of the Public Health Service was passed on June 16 by Congress, overriding a presidential veto. The amount authorized for research and training grants is \$1,250,000 less than the amount approved earlier by the House. The reduction was made by the Senate without the formality of receiving testimony on this phase of the Appropriations Bill and its action was sustained in the joint conference of the two houses. The amount approved by the House was, in turn, \$1,123,460 less than requested in the President's annual budget message. As a result the program for training, fully investigated, studied and recommended by a large number of civilian consultants had to be drastically reduced.)

#### E. Research

- 1. There is no clearing house, and thus no agency knows what research is being done in another and there is no coordination of the programs of the various agencies.
- 2. Progress has recently been made in some agencies to more or less guarantee the continuation of a research project. Many agencies, however, do not provide other than one-year grants which do not permit long-term planning and result in constant insecurity of the research worker because of lack of tenure and status.

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- 3. Funds available for research in psychiatry are pitiably weak, amounting to approximately \$2,000,000 of the \$120,000,000 spent for medical research.
- 4. Research is almost nonexistent in the area of preventive psychiatry. Minimal research has been done into the causation of mental illness and much must be done in developing shorter and more effective treatment. An important study still largely untouched is the rehabilitation of chronic psychiatric patients.
- 5. Social Research: If the government is to be concerned with the total problem of mental health it must devote much more attention to research in the social sciences, including such fields as human resources, morale, manpower, motivation, personnel policies. These are all of vital significance to many of the government, particularly to the military services.

#### F. Prevention

1. Inadequacy of the Program. Except for some inadequate investigations made in the military service and the grants under the National Mental Health Act by the Public Health Service to states (amounting to \$1,653,454 in 1948 and approved for \$3,550,000 in 1949), there is no program of prevention. Outpatient clinics in some degree are preventive in that they provide treatment earlier in the illness.

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- 2. Any preventive program will concern itself with many problems: public education, selection of leaders, consideration of policy in any and all federal agencies in regard to its effect on mental health, motivation and incentives, panic control, prejudice and discrimination, mental hygiene principles in academic education, mental health aspects in legal practice, mental health aspects of recreation, psychiatric aspects in delinquency and crime, the management of offenders, etc. None of these areas receives more than minimal, if any, consideration from this point of view.
- IV. Needed Changes for the Practice of Psychiatry and Neurology in the Federal Medical Services

The following recommendations are at best tentative. These recommendations could well be reviewed and a collective judgment obtained from a group of our best psychiatrists and representatives from their associates in clinical psychology, psychiatric social work and psychiatric nursing. Attention should be called to the fact that there has been a minimal attempt at coordination of medical services at high levels in the federal medical services. By contrast, the chiefs of the psychiatric divisions of the medical services have attempted to help each other and would be very agreeable to a coordinated effort.

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A. These recommendations are based on the assumption that there would be a cabinet post for health, with a physician as the Director General of the Medical Service. Such an organization would result eventually in the elimination of the health divisions of various agencies (except the military) as they are currently organized and operate. There would be a single unified federal medical service. There is an urgent need for unification to avoid duplication of physical facilities, to make the optimum use of the available personnel and to insure high quality in the training and research programs in the government medical services.

#### B. Organization structure

- 1. Basic assumptions would be to develop an organization to:
  - (a) Consider and aid in the solution of all problems of national health.
  - (b) Correct the inadequacies listed above.
  - (c) Avoid the amount of current red tape.
  - (d) Provide consultants at all levels, chosen from civilian life.
  - (e) Assure integration with the civilian medical program in every possible way.
- 2. Psychiatry and neurology would be a service parallel to medicine and surgery and such other specialties as are deemed of sufficient importance, grouped into a Professional Division. At the top of the Neuropsychiatry Division should be a director, and associated immediately with him two sub-groups:

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- (a) A small full-time coordinating and planning group with responsibility for the total mental health picture of the nation.
- (b) A powerful consulting advisory group from civilian life.
- 3. Sections of the neuropsychiatric service would include:
  - (a) Hospitalization Section, including both clinical work and construction.
  - (b) Outpatient Clinic Section.
  - (c) Preventive Psychiatry Section with a liaison with various other government agencies, particularly

    Vocational Rehabilitation, Children's Bureau, Office of Education, Departments of State, Labor, Justice,

    Divisions of Welfare, Correction (prisons), etc.
  - (d) Research (Coordination, grants, clearing house, etc.)
  - (e) Training of Professional Personnel.
  - (f) The ancillary divisions of clinical psychology, psychiatric social work, and psychiatric nursing,
- 4. Regional offices for administration of the clinical services in outpatient clinics and hospitals. There might also need to be representatives in regional offices to be concerned with training and research programs.
- 5. Some type of relative autonomy for major training and research centers, directly responsible to the chiefs in these fields in the central office.

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- 6. A regional system of effective civilian consultants.
- 7. A study should be made of the various state hospital systems and, where these facilities are adequate, the federal services should investigate the possibility of using these state hospitals under some type of per diem or contractual arrangement. It is felt that there should be a possibility for a great deal more free exchange of patients between the two tex-supported systems. The difficulty seems to be one of accounting and administration, rather than actual care of patients. As the state systems improve throughout the nation, it is possible they might carry an ever-increasing number of the patients for the federal medical services, particularly the chronic custodial type of patient.

#### C. Clinical Service

of the federal agencies should attempt to provide opportunity for specialization in the treatment of psychiatric disorders in general hospitals as well as in convalescent hospitals. In a total federal system this should be possible. The only exception to fusion of all hospital efforts must be made for the military for overseas installations, dispensaries, station and field hospitals, mental hygiene clinics in

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- basic and boot training camps, and psychiatric services on larger naval vessels and hospital ships. All necessary medical services of the military should be combined.
- 2. The mental hygiene clinic or outpatient clinic program should be expanded. It should be expanded in the following ways. Cases should be admitted regardless of service connection. There should be mental hygiene clinics available in the hospitals in the urban areas and in urban areas where hospitals are not available the government would find it economical to put mental hygiene clinics. It is felt that these recommendations are sound medically and economically for the reason that:
  - (a) Either the state or federal government takes care of all chronic patients in the neuropsychiatric field.
  - (b) The federal government gives hospital care to these patients irrespective of service connection.
  - (c) It has been shown repeatedly in clinical experience that outpatient care can prevent the development of some serious disorders and can discover many of them in a treatable phase.
  - (d) Early treatment keeps many nationts from becoming chronic, and thus avoids the expense of prolonged hospitalization.

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Company of the second of the s Marketing the same of the same (e) In many instances early treatment enables a patient to continue to work and support his family, so that they do not become an economic burden upon the community.

All experienced workers in the field agree that an outpatient program does much to prevent the development of serious disease, and can do much to cut down on overall cost of psychiatric care. Perhaps examples will show the rationale of clinic operation. Every veterans hospital contains many chronic psychoneurotic patients. A great many of these patients could have been restored to usefulness as citizens had their neuroses been attacked in a skillful manner during its early or formative phases. Instead, most of them were allowed to shop from physician to physician, receiving unneded physical manipulation and little psychiatric understanding until the problem became so fixed that they are now chronic neurotic invalids, beyond the help of anybody.

another example can be drawn from cases of general paresis. Each paretic patient at one stage of his illness was an early syphilitic and treatable. Because most cases of syphilis are not service connected these persons have not had treatment by the Veterans Administration, in many instances have not had adequate treatment

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been allowed to develop a chronic, deteriorating, psychotic type of illness. Even after the paresis itself develops it is still treatable if detected in the early stages. In the VA program these patients cannot be seen or examined in the clinic in the early phases but must deteriorate or progress to the point of being problems in the community before they can be referred to the VA hospital. By this time many are beyond help and join the ranks of the many chronic deteriorative cases which live for years in hospitals at government expense.

3. In many instances the payment of an allowance for disability claims tends to prolong the illness. This is particularly true in the neuroses. Because of this fact and the experience of national insurance companies in this field, it is recommended that a thorough study be made of the disability allowance system as it applies to psychiatric illnesses.

The extensive development of the psychiatric outpatient treatment clinics should utilize wherever possible organized civilian medical groups, as well as individual physicians. The federal medical services could take the lead in counteracting a long standing tradition of considering mental illness only in terms of hospitalization and inpatient treatment.

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- 4. Any system of major hospitalization under the auspices of a specific agency should be eliminated with simultaneous plans for further extension of hospital needs through the utilization of civilian hospitals.
- 5. Careful study should be made of the desirability and possibility of a federal relationship with state institutions for mental illness (to provide advice, establishment of standards, some types of services, information centers, grants-in-aid, etc.)
- 6. Provision of Refresher courses in psychiatry should be provided for all federal physicians, stressing the role of emotional factors in illness.
- 7. Special emphasis should be placed upon the rehabilitation program in all cases of permanent disability and chronic illness, in line with the newer knowledge in this field and the programs established under Doctor Rusk and others. In all probability many chronically ill patients in hospitals, if placed under such a system, could be rehabilitated.
- 8. Any additional hospitals for prolonged care of the more chronic patients should be built as part of or near general hospitals and all hospitals should be in or as near as possible to large medical and teaching centers.

  This is important in order that the federal hospitals may have the advantage of the teaching and clinical

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- experience of the teaching institutions and that their staffs have the stimulus of working with the people in these medical centers.
- Deliquency and crime cost the country conservatively 9. more then ten billion dollars a year. The cost of crime probably far exceeds the cost of disease. Such behavior is symptometic of emotional maladjustment. Mere punition does not rehabilitate this group. In the sense that misbehavior is a social and emotional maladjustment, all prisoners-federal, state or local -- need scientific evaluation. Currently they receive essentially no consideration from either medical or social scientists. A truly medical rehabilitation program with strong psychiatric guidance would unquestionably pay enormous dividends. As yet research in criminology as a psychiatric phenomenon, or in the prevention of delinquency and crime, is essentially nonexistent.

#### D. Personnel

 Steps must be taken to eliminate duplication, unnecessary assignments, and consequent waste of physicians,

er.

- 2. Definite long-term plans must be made to meet the shortage of professional personnel in the field of psychiatry by a program to graduate 1000 qualified psychiatrists per year.
- 3. There must be a revemping of personnel policies

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including methods of assignment, rank, advancement, tenure, salary, privileges, recognition, incentives, reduction in administrative work by professional personnel.

4. All professional personnel must be removed from the civil service system.

## E. Professional Training

- 1. Extensive and immediate subsidy is urgent for the inauguration or extension and improvement of:
  - (a) The curriculum in medical schools where special attention must be given to the inadequacy of current psychiatric training.
  - (b) Postgraduate training in civilian training centers.
- 2. A coordination and unification of standards of the current federal program in training centers is needed
- 3. A training program should include provision for subsidy with individual stipends for:
  - (a) Clinical Psychologists
  - (b) Psychiatric Social Workers
  - (c) Psychiatric Nurses
  - (d) Occupational, recreational educational therapists.

The training program for residents and ancillary personnel should continue and should be expanded under provision for government subsidy. This is imperative because the manpower shortage is the greatest problem in the psychiatric and neurological fields in the federal

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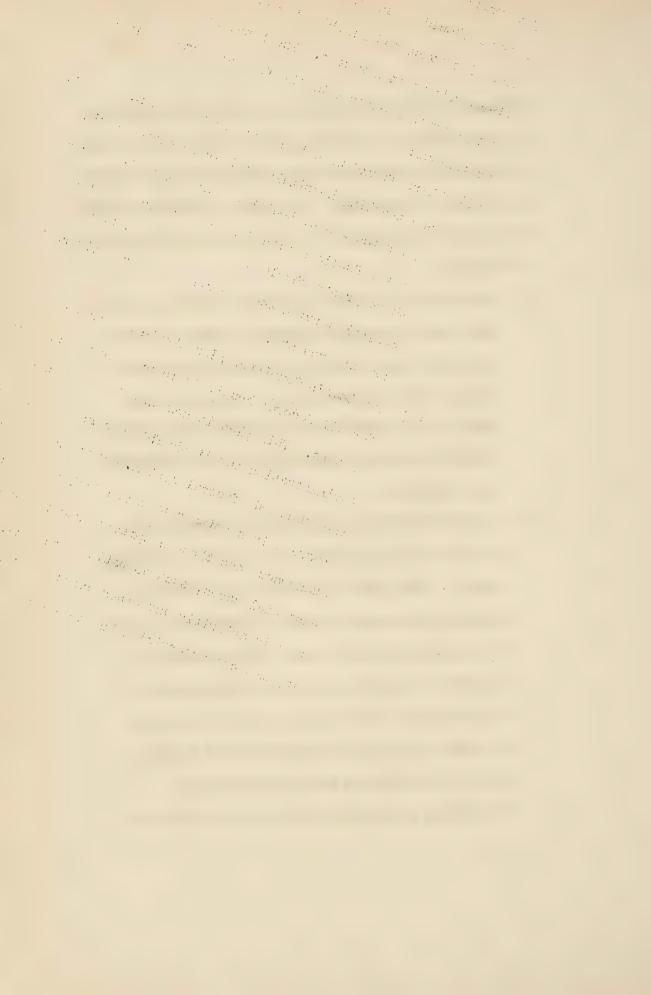
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en de la Maria de la Sala de Maria de la government and in the country as a whole. The training program should be an integral part of the unified federal medical service and should not continue to operate under five heads as it now does. The types of residency training programs sponsored by the federal service should be as follows:

- (1) There should be stipend grants to teaching centers and teaching hospitals similar to those provided under the Mental Health Act as now administered by the Public Health Service. It is felt that these grants should be made by the unified federal medical service and supervised by the universities as at present.
- (2) The Dean's Committee plan should be inaugurated for all federal hospitals in or near the teaching centers. This plan is now used by the Veterans Administration and it should be carried over into the unified federal system. Those residency programs in hospitals that are isolated should be abandoned and these hospitals used for chronic custodial cases, such as patients with senility, chronic arthritis and other cases requireing medical supervision but no active treatment.



- (3) There should be some provision for certain military personnel to be assigned for training on detrched service as is now practiced. These officers should be able to go into the general hospitals of the federal medical service or to university hospitals or wherever they might obtain the best training of the type desired. The training of the ancillary personnel, the psychologist, the psychiatric social worker and the psychiatric nurse, should continue. These programs can be carried on in the same manner as the physicians! training outlined, that is they should be able to apply for stipend grants made to universities or they should be sent on assignment to certain federal hospitals where they are supervised by consultants working under the supervisory university or teaching institution. Or, they could in some instances be sent on detached service by one of the military forces. It is important that the government continue in the training of these persons because there is a tremendous shortage in this field, and these people are needed because:
  - (1) There is great use for them in the routine care and management of patients.
  - (2) They make many contributions to research, particularly in the psychological field.

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n de la completa de la comp (3) They relieve tremendously the clinical burden placed on the few trained psychiatrists.

#### F. Research

- 1. The establishment of a unit as a clearing house for research which could provide information to any research group of the projects currently in progress.
- 2. Research in psychiatry and neurology needs great expansion. This research program should be carried forward under:
  - (a) Research grants made to already established research institutions and hospitals, and
  - (b) Contracts to universities and hospitals now engaged in research. These contracts can be of two types:
    (1) Contracts let to the university where the work is done in the university; (2) contracts to the university to continue on the work in one of the government hospitals and utilizing some government personnel; and (3) research can be carried on in government institutions by government personnel.
    (4) Individual research fellowships.
- 3. Consideration of the assignment of target research in the areas of:
  - (a) Prevention
  - (b) Causes of mental illness
  - (c) Effective and shorter therapeutic measures
  - (d) Rehabilitation of chronic patients,

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- 4. Subsidy and coordination of research in the social sciences as suggested under III E 5.
- 5. The entrance of the government medical services into research except within the armed forces seems a questionable procedure. Undoubtedly they can coordinate, stimulate (through subsidy) research in an extremely effective way. The subcommittee questions the wisdom of such centers as the projected National Institute of Mental Health because:
  - (1) It would seem wiser to have the research projects carried on in universities and other medical centers, and
  - (2) It is questionable whether a research staff could be made available to operate it without actually robbing research personnel from existing civilian agencies.

#### G. Prevention

1. The inauguration of a program of preventive psychiatry.

This would include the obvious steps in the development of plans for a program of public education to set forth mental hygiene principles for the average man, child guidance, parental education, preventive programs in high schools and colleges, in industry, in courts and legal practice, etc.

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- 2. An intra-governmental education program regarding the importance of policies and their effect on mental health; the selection of leadership; morale; manpower problems and resources; etc.
- 3. A program of immediate research in panic prevention.

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DOCUMENT SECTION

COMMISSION ON ORGANIZATION OF THE EXECUTIVE BRANCH OF THE GOVERNMENT

#### APPENDIX F

REPORT OF THE
SUBCOMMITTEE ON ARMID FORCES HOSPITALIZATION
COMMITTEE ON FEDERAL MEDICAL SERVICES

Paul R. Hawley, M.D. Michael E. DeBakey, M.D. William C. Menninger, M.D. Hugh J. Morgan, M.D.



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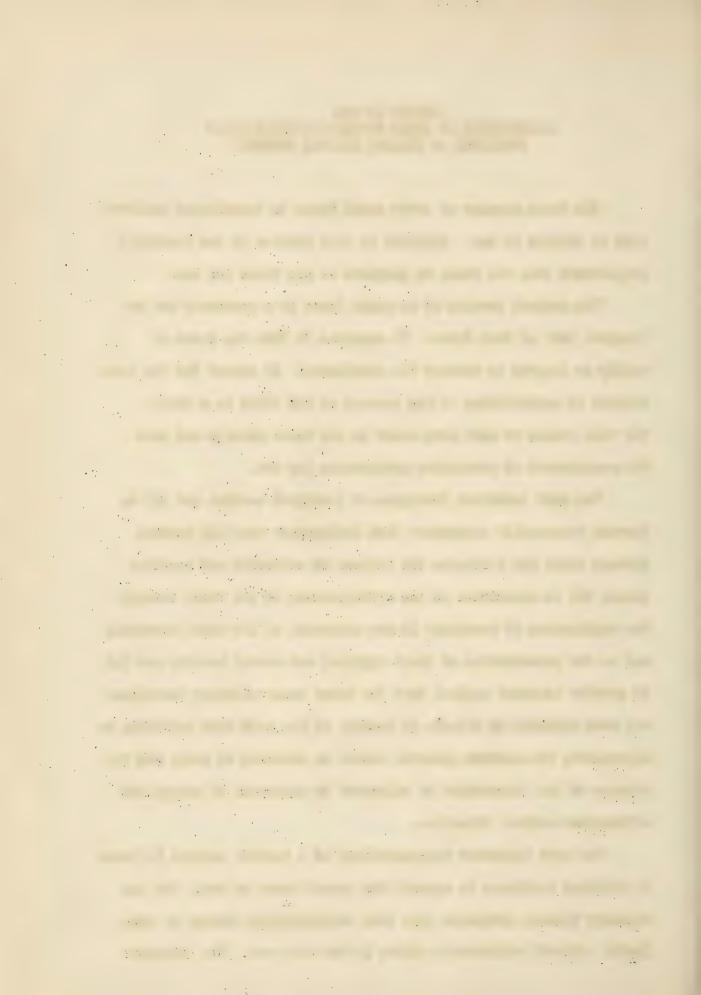
# REPORT OF THE SUBCOMMITTEE ON ARMED FORCES HOSPITALIZATION COMMITTEE ON FEDERAL MEDICAL SERVICES

The basic mission of every armed force is expeditious achievement of victory in war. Inherent in this mission is the essential requirement that the force be prepared at all times for war.

The medical service of an armed force is a necessary and an integral part of that force. To separate it from the force is wholly or largely to destroy its usefulness. It exists for the sole purpose of contributing to the success of the force as a whole. For this reason it must both share in the basic mission and meet the requirement of continuous preparation for war.

The more important functions of a medical service are (a) to furnish responsible commanders with information upon all medical factors which may influence the success of strategic and tactical plans; (b) to contribute to the effectiveness of the force through the application of knowledge in the selection of its human elements, and in the preservation of their physical and mental health; and (c) to provide adequate medical care for those whose military usefulness has been impaired by disease or injury, to the ends that suffering be alleviated, the maximum possible number be restored to duty, and the courage of the able-bodied be bolstered by assurance of prompt and efficacious medical attention.

The most important responsibility of a medical service in peace is constant readiness to support its parent force in war. Our own military history indicates that this responsibility cannot be neglected without unfortunate effect in the next war. The exclusive



employment during peace of a medical service of an armed force in the routine care of the current sick and injured no more prepares it for war than would comparable employment of fighter pilots in commercial aviation, or of infantrymen in municipal police forces, prepare them for war.

However, the fact that medical care of a peace-time force is indefensible as the sole duty of a medical service in no way minimizes the importance of this responsibility. Always a prime consideration, the provision of adequate medical care for the armed forces has now become a matter of the gravest concern.

As regards the function of providing medical care for the armed forces, the traditional pattern is one of complete care for all disabilities. This ranges from the treatment of minor disabilities too slight to warrant relief from duty to the most serious conditions requiring expert care in fully-equipped hospitals. It has been the policy for many years to retain all surviving disabled in service until they have received maximum benefit from hospitalization. Not infrequently this results in the retention of cases in military hospitals for one, two, or even three, years after their military usefulness has ended. A medical service of this extent requires that military hospitals of the scope of general hospitals be staffed with full panels of specialists if first-class medical care is offered.

Medicine has advanced so rapidly in the past 25 years that the standards of medical care of only a few years ago are wholly unacceptable today. The physician with good general training still occupies an important niche in the medical structure — one of increasing importance — but even he no longer considers himself competent to apply the highly specialized techniques of recent development which are proving so effective in the saving of life and limb.

The numbers of doctors in the medical services of the armed forces is numerically insufficient at present for them to meet all of their responsibilities; and their shortage in medical specialists are much more critical. A large proportion of their present medical officer strength is made up of young physicians whose medical education was subsidized, in whole or in part, by the A.S.T.P. and V - 12 programs of World War II. These young gentlemen have received excellent general training, but no specialist training of a scope to qualify them in these fields; and their experience is necessarily limited by their recent graduation. Many of them eventually will become leaders in their profession; but at present their skills fall far short of the expertness demanded by modern medical knowledge.

Furthermore, these young physicians are now serving under compulsion, as a partial return for the Government's contribution toward their education. Their terms of service will expire not later than 30 June 1949. This will create a still greater shortage of medical officers — a paralyzing shortage. Voluntary recruitment has thus far failed to fill present vacancies, and assuredly will fail to replace the excessive losses of the next six or eight months. This is an incontrovertible fact.

The general Selective Service Act will produce but an

insignificant number of physicians for the armed forces. The upper age limit and the several grounds for exemption will exclude all but a few.

The only remaining alternative is a special draft of physicians, and it is generally accepted that this will be necessary if the armed forces are to be given any kind of care. However, it is inconceivable that the Congress would not make service in World War II a ground for the exemption of physicians as it has done for general compulsory service. Since the vast majority of medical and surgical specialists of military age and fitness -- perhaps 85 to 90 per cent -- served in the armed forces in World War II, including the younger group who have completed their specialist training since the war, even a special draft of physicians cannot possibly produce specialists in the numbers required. The pool of eligibles from which physicians could be drafted is limited almost entirely to recent graduates of limited training and experience, wholly unqualified to assume the heavy responsibilities of a modern first class medical service; and the number of qualified specialists left in the medical services is woofully inadequate for the proper supervision and training of these fledgling doctors.

Under the existing pattern of military medical practice, and with the medical talent now in sight for this duty, it is certain that the quality of medical care is certain to drop even if the strength of the armed forces is not augumented.

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This serious problem of the present, however, becomes critical with the operation of the Selective Service Act. Thousands of young Americans are to be compelled to serve in the armed forces. It may be accepted that these young men, their families and their friends — a number comprising a large proportion of our population will — expect and demand for these inductees a quality of medical care no less than that given the armed forces during World War II. The slightest relaxation of this standard is certain to produce serious repercussions; and a significant departure therefrom may well threaten the very security of the nation through repeal of the Selective Service Act. The quality of medical care during World War II was excellent only because of the availability to the seriously sick and injured of an adequate number of medical and surgical specialists. This quality cannot again be approached under any other conditions.

It must be accepted then, that, unless such expert medical skills are — in one way or another — made fully available to the sick and injured of the armed forces, thousands of young Americans will have been forced from their homes and vocations to serve a Government that is indifferent to their welfare. This is not a pleasant thought, but it is the truth.

The situation is, then, that the medical services of the armed forces are now inadequately staffed, both in numbers and in medical and surgical specialists, and that this shortage is certain to increase within the next few months at a time when the need will be rapidly increasing. How can this problem be solved?

As has already been pointed out, voluntary recruitment has failed thus far and seems certain to fail for a long time to come. The number of physicians per capita in the United States has been declining for 20 years. The cost of medical education has risen steadily and the revenues of medical schools have lagged far behind this hot pace. The cost of establishing a new school of medicine is almost prohibitive and, until radical innovations in the financing of medical education are forthcoming, there is little hope for a significant increase in the number of medical graduates per year. More and more medical graduates are turning at once to the specialties; and Federal salary scales offer no inducement to a physician who has invested three to five years in postgraduate work over and above a long and expensive basic medical education.

It is to the great credit of the medical profession of the United States that voluntary recruitment has fully met the medical needs of our armed forces in all of our wars. More we again at war, there is little question but that this problem would be again solved in this manner. However, in World War II the interplay of the factors of a proportionately decreasing number of physicians and an increasing need for specialists in the armed forces made this solution barely tolerable for the civil population. The country was most fortunate during those war years in escaping both epidemics and enemy attack upon the civil population. Had either of these contingencies occurred, those at home would have suffered for lack of sufficient medical care. With the rapid development of new weapons for total war, the medical needs of the civil popu-

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lation must henceforth be given much greater consideration in the distribution of medical resources in war.

This subcommittee is of the definite opinion that the medical needs of both the armed forces and the civil population can no longer be met by the traditional pattern of medical service in war — at least not until either medical requirements are materially lessened or medical resources considerably increased. One group or the other will suffer through over-dispersion of limited professional skills. Better utilization of available talent is imperative.

In exploring the possibilities for more efficient use of the medical potentialities of the nation, this subcommittee early arrived at the firm conclusion that so much of a medical service as is in direct support of an armed force is, and must continue to be, inseparable from that force. The functions of a medical service are too diverse, and the responsibilities of commanders too inclusive, for medical personnel to be allocated and withdrawn solely on the basis of current need for medical care.

There is at present, however, a function of medical service that is not one of direct support of an armed force. This is the purely professional care in hospitals of the serious cases requiring expert medical or surgical skills. A high proportion of such cases are forever unfit for further military service; and such as do fully recover are of little military value during the period of their hospitalization. Such patients are primarily a medical rather than a military responsibility; and, while there

are many sound reasons for not separating those of further usefulness from military control, there is no impelling reason for treating them in military hospitals.

Approximately 28 percent of the 7,241 medical officers on duty with the armed forces on June 30, 1948 were on duty in military hospitals of general hospital caliber (19 percent of 4,353 for Army and Air Force and 41 percent of 2,888 for Navy); and at least 90 percent of the requirements for medical and surgical specialists are for such institutions. The one major responsibility of the medical services of the armed forces that cannot be met adequately either by voluntary recruitment or reasonable compulsory service of physicians, then, is the operation of that class of hospitals that are capable of providing highly expert care and treatment.

These convincing facts point only to one conclusion — that, if adequate medical care is to be given the armed forces, the services of expert medical and surgical specialists must be made available in some way other than by induction for full-time employment. There is no other solution.

Fortunately, a precedent for such solution has been established by the Department of Medicine and Surgery of the Veterans Administration. Faced with almost the identical problem, this Department obtained the services of hundreds of outstanding specialists upon a part-time basis. This program has been in operation for almost three years, and its success is no longer in doubt. Of the 91,290 patients now in veterans hospitals on June 30, 1948, the professional treatment of about 58,000 was given wholly by, or under the close

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supervision of, part-time specialists. To provide these services with full-time personnel would require the withdrawal of at least 1,250 specialists from the limited medical pool of the country. Here, then, is a happy example of thousands of patients, for whom the Federal Government is responsible, being afforded medical care of the highest quality, and — which is of utmost importance in the utilization of medical resources in war — without noticeably reducing the amount of medical service available to the rest of the population.

In the past year or so the medical services of the armed forces have instituted a program that is similar in some respects to that of the Department of Medicine and Surgery of the Veterans Administration. It is not an identical program, and it fails to accomplish the most important desideratum in the present situation in that the services of part-time specialists are, with few exceptions, limited to consultation and to instructions of full-time personnel. With such limitation there is neither a reduction in the number of full-time personnel required nor so great an assurance of expert skill in the treatment of patients. As a program for increasing the professional efficiency of full-time personnel, it is excellent. As a solution of this program, however, it has the insuperable defects of requiring sufficient full-time personnel of a quality capable of expertness after training, and years of time to complete the training of each individual The hopelessness of obtaining medical personnel in sufficient numbers, other than by compulsory service, is apparent. The time required for the training

of a specialist far exceeds any term of compulsory service that would ever be imposed upon medical men. It is highly wishful thinking to believe that a large proportion of volunteers will remain in the military service after completing specialist training. There is too great a disparity between military pay and the carming power of a specialist in civil practice. The military services have always suffered from resignations of medical men with special qualifications. The reason that more have not been lost is that heretofore medical men in the armed forces ordinarily have had to acquire special skills largely through their own uncassisted efforts. This is a slow process, and, by the time they had attained professional eminence, the years had given then too heavy an investment in the privilege of retirement to be sacrificed by a venture into civil practice. There were, of course, exceptions to this rule; but it applied in most cases.

Now that specialist training is being spoon-fed to young modical officers immediately upon their entrance into service, it will be completed in the armed forces as rapidly as in civil life; and these young gentlemen will encounter no disadvantage in age or opportunity in choosing civil practice. On the other hand, the higher pay during their years of training should provide a nest egg with which to begin private practice. As a means of staffing military hospitals with second-line medical men -- highly essential but no substitutes for skilled specialists -- the training programs of the medical services are excellent; but they are a highly dubious source of those essential skilled specialists.

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The shortages of dentists, nurses, and other allied medical specialists are even more acute than that of physicians; and the outlook for
obtaining sufficient numbers of all categories of medical personnel for
exclusive use by the armed forces is most discouraging.

Another important element of this problem is the medical responsibility assumed by the armed forces for the dependents of officers and enlisted men. Beginning with the provision of medical care for dependents in isolated stations, at home and abroad, where no other source of such care was available, this program has been extended to the point of providing complete medical care for all dependents and near-dependents. This has imposed a heavy load upon the medical services of the armed forces; and, in some hospitals at present, the care of such non-military personnel represents more than 50 percent of the work of the medical staff. In view of the critical position of the medical services of the armed forces, it is questionable whether this service can be continued in its present pattern.

These facts lead the subcommittee to the firm conclusion that an acceptable quality of medical care can be insured to the armed forces only by a radical departure from the traditional pattern of such care. The subcommittee is fully aware of the repercussions excited by any departure from tradition; but it is also conscious of the insurmountable obstacles that have recently come into the picture and which cannot be overcome in any other way.

First, the most economical use must be made of the limited amount of expert medical talent in the nation. No longer can it be dissipated through exclusive allocation to one or the other Federal medical service,

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or even to the exclusive service of the Government. The needs of the civil population must be protected in war as well as in peace. To this end the part-time services of specialists must be utilized to the fullest extent in staffing the military hospitals of general hospital caliber within the Continental limits of the United States. Obviously, such a territorial limitation is necessary, but only because their services are not available elsewhere in the world. These specialists on part-time must actually replace military medical men rather than, as at present, merely supplement numerically adequate staffs for purposes of instruction. They must be given responsibility for patient care as well as for teaching, using inexperienced medical officers as a house staff.

The utilization of civilian staff in purely military hospitals is open to two serious objections. First, there are the legal questions upon the control of civilians by the military; and, second, such employment of civilian specialists merely increases the competition among the Federal medical services for the services of these specialists. The Army, the Navy, the Air Service, the Veterans' Administration, The United States Public Health Service, and other Federal medical services would all engage in bidding in this strictly limited field. While legal obstacles to the employment of civilian physicians could probably be overcome without difficulty, duplication of effort and extravagance in the use of medical talent can not be justified at this critical time.

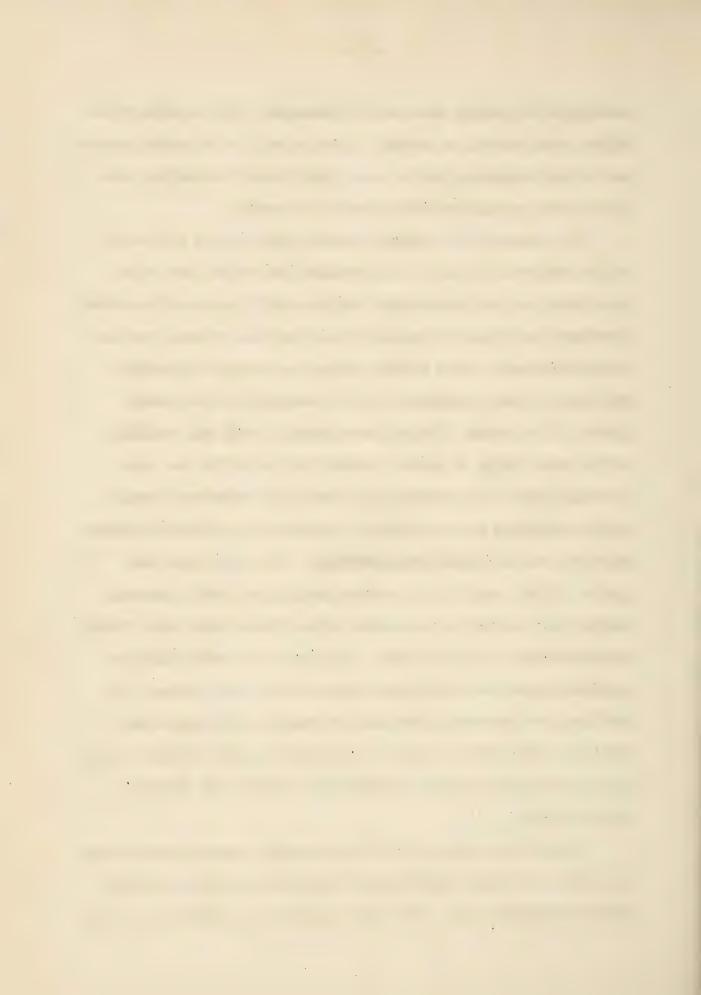
This leads the subcommittee to the conclusion that efficient and economical use by the Government of the limited amount of expert medical talent can be assured only through the establishment of a single system of Federal hospitals in which the bulk of the responsibility of the

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Government for medical care can be discharged. Such a system would effect great economy in hospital plant as well as in medical personnel of all categories; and it would least disturb the medical care of the civil population both in war and in peace.

The scope of this federal hospital system should include all of the responsibilities of the Government for medical care other than those that are inseparable from the armed forces and from other Government activities of peculiar nature such as, perhaps, the hospital departments within federal prisons -- although the medical staffing of prison hospitals could be undertaken by the general system. This federal hospital system should absorb all hospitals of the armed forces of general hospital caliber within the continental limits of the United States (with the exceptions hereinafter mentioned), and the existing hospitals of the Veterans Administration, and the Public Health Service. The armed forces must retain military hospitals of station hospital and naval dispensary caliber and less within continental United States where other federal hospitalization is not available. They must also retain military hospitals beyond the continental limits of the United States. In addition, for purposes of training and research, the Army should retain the Army Medical Center and the Navy the Naval Medical Center; and the Air Force should be permitted to construct the Aviation Medical Center.

If and when created, this federal hospital system should follow the pattern of medical staffing established three years ago by the Veterans Administration. The fullest possible use should be made of

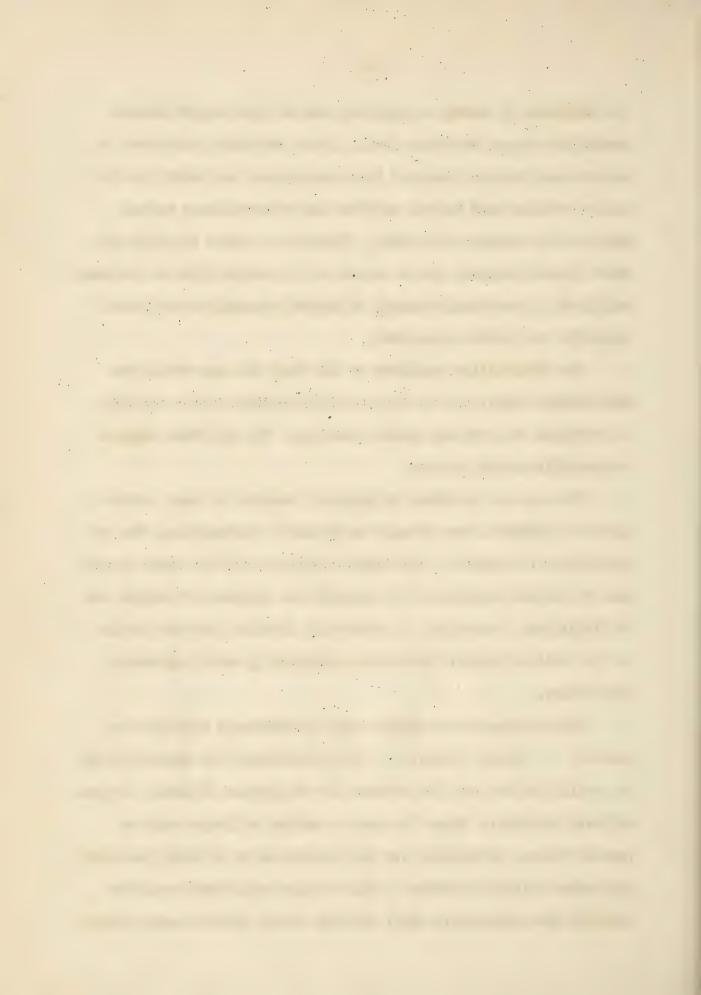


the faculties of schools of medicine, and of other expert medical specialists upon a part-time basis. These hospitals must serve the professional training needs of the armed forces, and permit the detail of commissioned medical officers and other military medical personnel to receive instruction. There is no reason why this proposed federal hospital system should not be charged with the responsibility of all technical training of medical specialists and technicians for the Federal Government.

The subcommittee considers it wise that the Army retain the Army Medical Center and the Navy the Naval Medical Center for military-medical research and special training. The Air Force requires a comparable medical center.

The care and treatment of military personnel in such a federal system of hospitals need present no insoluble difficulties. The use of military registrars in the larger hospitals, and for areas in the case of smaller hospitals, will simplify the problems of records and of discipline. Separation of permanently disabled from the service at the earliest possible date can be arranged by mutual agreement upon policy.

The question of the medical care of dependents must also be decided. It appears doubtful to the subcommittee that physicians can be legally drafted into the service for the purpose of caring for non-military personnel. Since the need of medical officers would be greatly reduced if medical care were restricted to military personnel, any number drafted in excess of this minimum requirement would be strictly for non-military duty; and this raises serious legal doubts.



Aside from the financial consideration involved, there is no longer any necessity for providing medical care to dependents and other non-military personnel within the continental limits of the United States. Adequate medical and hospital facilities are available in the vicinity of all military stations in this country. If the Federal Government desires to continue this privilege, it might well do so through the method of prepayment of medical care in an insurance plan. In certain, but not all, foreign stations, provision of medical care for dependents and other non-military personnel will be necessary.

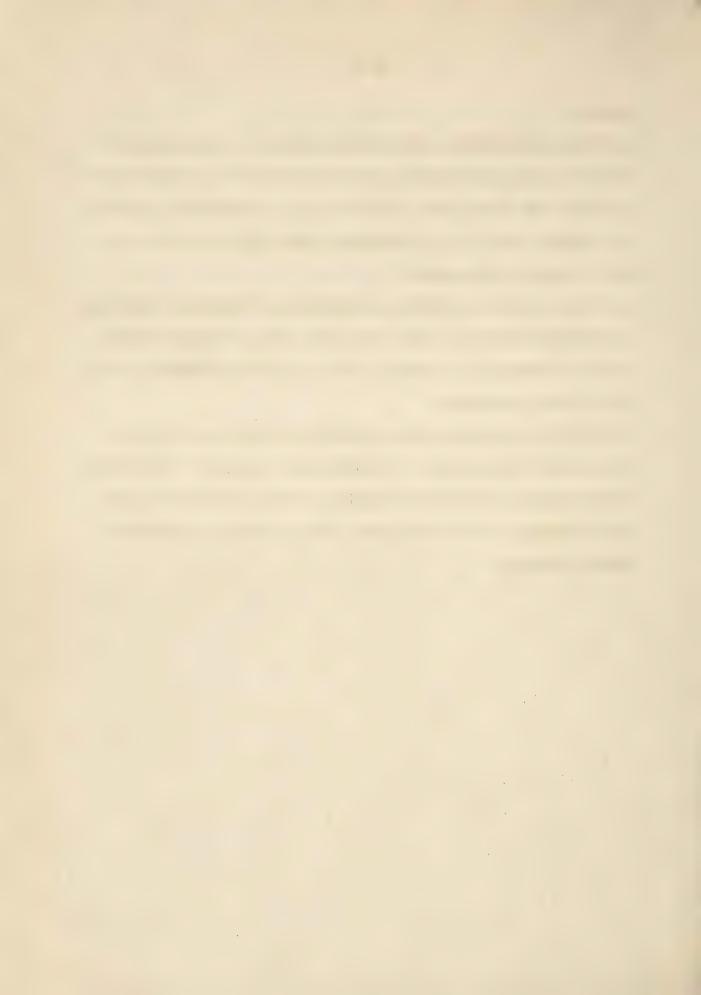
The proper place of the proposed federal system of hospitals in the general organization of the Federal Government is a matter for the determination of the Subcommittee on Organization. For the consideration of the Subcommittee on Organization, it is suggested that all medical activities of the Federal Government, other than those retained by the armed forces, might well be gathered into one large medical agency.

In the interest (a) of assuring the armed forces of medical care of acceptable quality, and (b) of conserving the limited amount of medical talent available in the United States, this subcommittee recommends:

1. That a single system of federal hospitals be created to absorb the hospitals of the Veterans Administration, the United States Public Health Service, the Indian Service, and the military and naval hospitals within the continental limits of the United States of the caliber of general hospitals, except the Army Medical Center and the Naval Medical

Center.

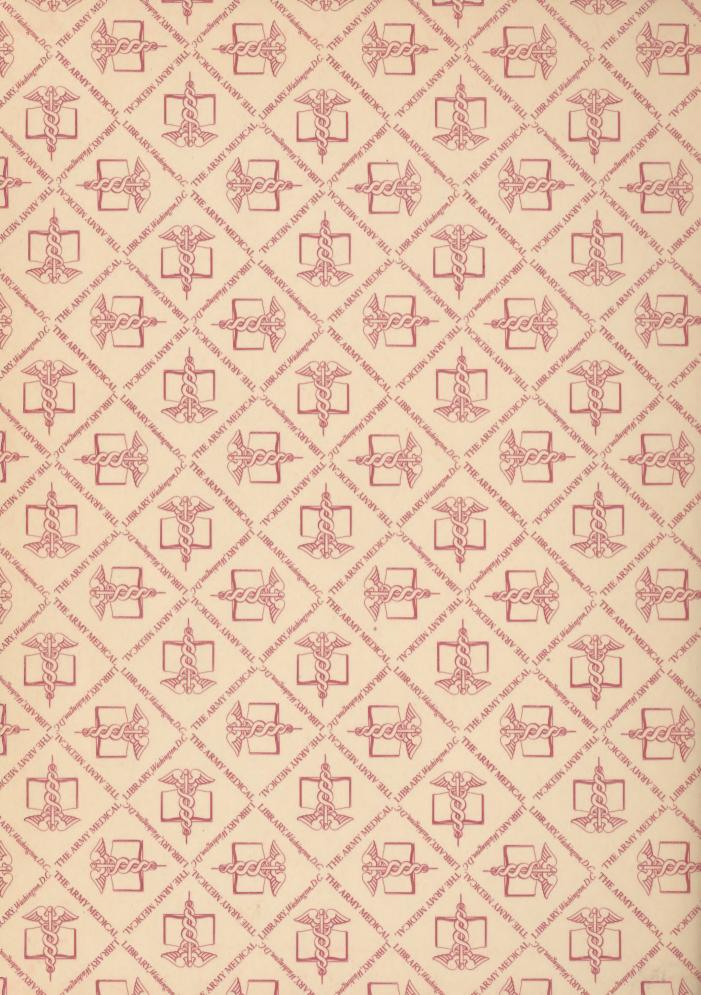
- 2. That hospitalization offered by the armed forces be restricted within the continental limits of the United States to the Army Medical Center and Naval Medical Center and, when established, the Aviation Medical Center, and to hospitals of the caliber of station hospitals and naval dispensaries.
- 3. That, except in emergencies, medical care of dependents and other non-military personnel, at all places where other adequate medical service is available, be arranged for in other than hospitals of the United States Government.
- 4. That the part-time services of civilian specialists be used to the greatest extent possible in staffing the hospitals of the federal hospital system; and that the facilities of these hospitals be made freely available to the armed forces for the training of military-medical personnel.















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